HB

407

(File 1)

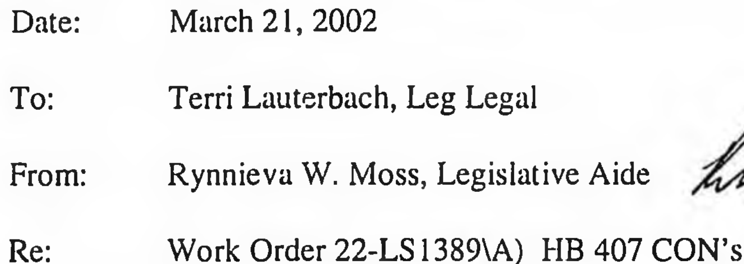
ALASKA STATE HOUSE OF REPRESENTATIVES

Interim Address:
119 N. Cushman, Suite 211
Fairbanks, AK 99701
(907)-456-5081
Fax# (907)-456-8245

Session Contact:
(907)-465-3719
FAX# (907)-465-3258
State Capitol
Room 102

REPRESENTATIVE JOHN COGHILL

Memorandum



Date: March 21, 2002

To: Terri Lauterbach, Leg Legal

From: Rynnieva W. Moss, Legislative Aide

Re: Work Order 22-LS1389\A) HB 407 CON's

Representative Coghill would like a CS with the following changes:

1. Exempt psychiatric beds and nursing homes from Section 1.
2. Require the Department to set a time limit in regulation for determination of the completeness of a certificate of need application.
3. Require that a CON must be approved or denied within 120 days of when the application is determined to be complete.
4. Require the department to set limits and procedures in regulation for when a public hearing must be held.
5. Amend AS 18.07.031(c) to allow all facilities requiring CON's to relocate without a new CON as long as the replacement facility does not increase bed capacity, number of categories of services, or new categories of service.
6. Amend AS 18.07.031 to provide that a facility can be replaced on the same site without obtaining a CON as long as the replacement facility does not increase bed capacity, number of categories of services, or new categories of service. You mentioned that if a facility was destroyed, they would no longer be in business and could require a new CON process to replace the facility.
7. Fold AS 18.07.041 facilities into AS 18.07.043.
8. Provide that this act applies to applications for certificates of need initially filed after the effective date of the Act.

Representative_John_Coghill@LEGIS.state.ak.us

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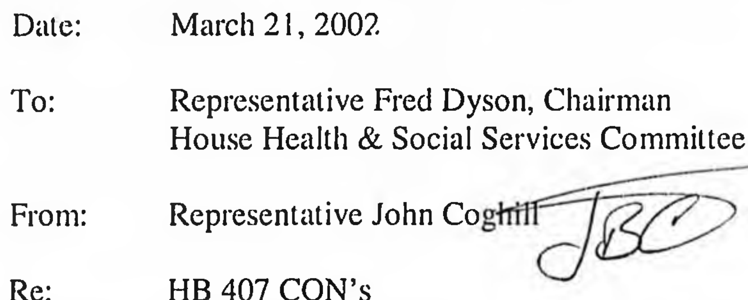
REPRESENTATIVE JOHN COGHILL

Memorandum

Date: March 21, 2002

To: Representative Fred Dyson, Chairman
House Health & Social Services Committee

From: Representative John Coghill



Re: HB 407 CON's

I am requesting that HB 407 "Relating to Certificates of Need" be scheduled as soon as possible for a hearing before the House HESS Committee. I have enclosed relevant back up for the bill.

Thank you for your consideration.

Representative_John_Coghill@LEGIS.state.ak.us

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 407
( ) Publish Date:

Revision Date/Time (Note if correction):
Title: RELATING TO CERTIFICATES OF NEED
Sponsor: COGHILL
Requestor: HOUSE (CRA)

Dept. Affected: Health & Social Services
BRU: Medical Assistance
Component: Medicaid Services
Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	732.0	30,223.7	35,361.7	41,373.2	48,406.6	56,235.7
Miscellaneous						
TOTAL OPERATING	732.0	30,223.7	35,361.7	41,373.2	48,406.6	56,235.7

CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
1002 Federal Receipts	426.5	17,613.5	20,605.2	24,108.2	28,206.5	32,768.5
1003 GF Match	305.5	12,610.2	14,756.5	17,265.0	20,200.1	23,467.2
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--do not abbreviate)						
TOTAL	732.0	30,223.7	35,361.7	41,373.2	48,406.6	56,235.7

Estimate of any current year (FY2002) cost:

Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal: [ ]

POSITIONS

POSITIONS						
Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill would exempt from Certificate of Need (CON) any facility construction, alteration or addition of health services if the activity occurs in any community with a population in excess of 55,000 (Anchorage, Fairbanks or Mat-Su). The bill would eliminate 2/3 of the current CON reviews and allow extensive construction to occur in the most urban areas of the state, where there is already significant capacity of health care services and a number of CONs filed. This fiscal note assumes that all the CONs on file will be built.

The Medicaid Rate Advisory Committee estimates that a hospital capital expenditure of $10 million amortized over 15 years at a Medicaid utilization rate of 20% will result in $150.0 annual operating cost for the Medicaid Program.

Prepared by: Nancy Weller — Phone 465-3355
Division: Medical Assistance — Date/Time 02/28/2002
Approved by: Elmer A. Lindstrom, Deputy Commissioner — Date 03/04/2002
Agency: Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

(Rev 2/7/2001 OMB)

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

BILL NO. HB 407

ANALYSIS CONTINUATION

Nursing Facilities in the state average 80% occupancy, and a 20 bed nursing home will cost Medicaid an additional $2.5 million annually. There are currently pending 165 nursing home beds, and 44 acute psychiatric beds.

What is not reflected here are all of the other projects unknown to the Department that may be build if there are no controls on new beds or services. Unrestrained construction of these facilities could cost the state $30 to $50 million in new funds every year in Medicaid costs.

Potential New Beds if CON is Exempted for Anchorage, Mat-Su, and Fairbanks

Nursing Home Beds:

Location	Facility	No of Beds	Cost Per Bed Day	Annual Cost
Fairbanks	Denali Center	15 NH Beds	$ 345.49	$ 1,607,824
Mat-Su	Valley Hospital	60 NH Beds	$ 389.46	$ 7,249,798
Anchorage	Mary Conrad	20 NH Beds	$ 248.52	$ 1,542,067
Anchorage	Providence	40 NH Beds	$ 251.28	$ 3,118,385
Chugiak	Chugiak Sen Ctr	30 NH Beds	$ 389.46	$ 3,624,899

Psych Beds:

Location	Facility	No of Beds	Cost Per Bed Day	Annual Cost
Anchorage	Providence	26 Beds	$ 1,584.00	$ 8,845,848
Mat-Su	North Star	18 Beds	$ 525.00	$ 4,234,913
Total		165 NH; 44 Psych		$ 30,223,733

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REPRESENTATIVE JOHN COGHILL

HB 407 Certificate of Need
Sponsor Statement

In trying to preserve the free enterprise system, I will do all that I can to protect our open market and the consumer's choice. This bill is an attempt to do this in the world of health care.

Under the current state statutes, if a health care provider in Fairbanks or the Mat-Su Borough wanted to build or supply services over $1 million dollars worth, they would have to obtain a Certificate of Need. In applying for that certificate of need they would have to prove to the government that a proposal would not adversely affect other health care facilities. This puts the government in charge of who can deliver health care in any area. I would rather see the customer and the health care providers have a greater choice in the market dynamics.

I don't believe that by eliminating the CON requirement for larger Alaskan communities there will be large influx of new medical facilities. This may have been true when the federal government subsidized CON programs, but the federal CON law was repealed in 1996. Since the repeal of the federal law, 14 states have repealed CON's. Another ten states have eliminated CON requirements for acute care facilities and additional nine states do not require CON's for ambulatory surgical centers.

More ambulatory surgical centers in Fairbanks would not, in my opinion, mean less business for existing facilities. It could mean however, more choices in providers and that fewer Fairbanksans may have to travel to Anchorage or the lower forty-eight for a medical procedure.

According to the attached *Heartland* article, in 1996 the Federal Trade Commission estimated that CON regulations increased the cost of hospital care nationwide by more than $1.3 billion annually.

This legislation will encourage competition in the larger Alaskan communities where the population would support competition while protecting the fragile balance of health care services in the smaller Alaskan communities.

Representative_John_Coghill@LEGIS.state.ak.us

WHAT IS THE RIGHT POPULATION NUMBER?

U.S. Census provides extended information for communities 25,000 and over	25,000
125% of Federal Level standard conversion for poverty level for medical assistance	31,250
150% of 125% level of poverty level for medical assistance	46,875
175% of 125% level of poverty level for medical assistance	**54,688**
200% of 125% level of poverty level for medical assistance	62,500

ORGANIZED BOROUGH POPULATIONS

Anchorage Borough	260,283
Fairbanks North Star Borough	82,840
Matanuska-Susitna Borough	59,322
Kenai Peninsula Borough	49,691
Juneau Borough	30,711
Ketchikan Gateway Borough	14,070
Kodiak Island Borough	13,913
North Slope Borough	7,385
Northwest Arctic Borough	7,208
Aleutians East Borough	2,697
Haines Borough	2,392
Lake Peninsula Borough	1,823
Bristol Bay Borough	1,258

THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

Statement of Revenues and Expenses — Providence Alaska Medical Cntr

	1998	1939	2000	2001	2002	2003	2004
REVENUES							
Gross Patient Revenue							
Inpatient Gross Revenue	$ 238,536	$ 254,306	$ 269,044	$ 283,807	$ 301,159	$ 328,486	$ 354,653
Outpatient Gross Revenue	101,579	109,508	129,039	141,935	156,147	179,789	207,083
Total Gross Patient Revenue	340,115	363,814	398,083	425,743	457,307	508,274	561,736
Contractual Allowances							
Medicare	39,036	51,463	60,299	65,791	71,729	85,369	96,892
Medicaid	31,622	41,386	48,100	52,266	56,771	64,436	73,086
Commercial	26,118	30,035	37,347	43,092	49,466	55,749	64,672
Other Contractuals	8,105	8,191	10,802	12,125	13,578	15,544	17,787
Charity	11,910	11,267	14,061	15,093	16,207	18,007	19,958
Total Contractual Allowances	116,791	142,342	170,609	188,367	207,752	239,105	272,396
Net Patient Revenues	223,324	221,472	227,474	237,376	249,554	269,169	289,340
Other Operating Revenues	11,743	8,774	9,298	9,577	9,864	10,160	10,465
Net Revenues	$ 235,067	$ 230,246	$ 236,772	$ 246,953	$ 259,418	$ 279,329	$ 299,805
EXPENSES							
Expenses							
Salaries and Wages	$ 87,956	$ 89,938	$ 96,073	$ 100,255	$ 105,631	$ 112,881	$ 120,530
Benefits	17,914	19,518	21,270	22,195	23,386	24,991	26,684
Supplies	33,704	34,276	36,347	38,424	40,623	43,917	47,413
Professional Fees	12,030	5,042	4,035	4,075	4,116	4,240	4,367
Purchased Services	25,858	29,459	23,650	24,470	25,320	27,215	29,220
Purchased Healthcare	-	-	-	-	-	-	-
Interest	2,435	2,536	2,197	1,887	1,555	1,235	915
Depreciation/Amortization	14,316	16,367	16,422	18,232	19,639	21,875	24,039
Bad Debt	9,733	12,545	11,334	12,168	13,067	14,521	16,097
Other Expenses	8,895	7,534	8,091	8,334	8,584	9,871	10,168
Total Expenses	$ 212,841	$ 217,215	$ 219,418	$ 230,040	$ 241,921	$ 260,746	$ 279,433
Net Operating Income	$ 22,226	$ 13,031	$ 17,354	$ 16,913	$ 17,497	$ 18,583	$ 20,371
Non-Operating Rev/Exp.	10,097	5,891	11,149	10,925	7,672	8,064	9,348
Net Income Before Taxes	32,323	18,922	28,503	27,837	25,170	26,647	29,719
Taxes	-	-	-	-	-	-	-
Excess of Revenues Over Expenses	$ 32,323	$ 18,922	$ 28,503	$ 27,837	$ 25,170	$ 26,647	$ 29,719

From a CON application submitted by Providence

CERTIFICATES OF NEED:
A BAD IDEA WHOSE TIME HAS PASSED

BY PETER DOHERTY

Certificate of need laws and regulations restrict health care commerce and should be abolished.

Looking back to the 1960s and 70s, it is in some ways hard to believe how much faith policymakers had in the ability of government to manage the marketplace. This statement may be especially true for those of us who describe ourselves as conservative. Ask us today, 20 years after the dawn of the Reagan Revolution, and many of us will vigorously maintain that we opposed intrusions of government into the marketplace. We spoke out and we fought the good fight against them, but the lingering impact of the New Deal, as amplified through the Great Society, overwhelmed us until Reagan rose to national power. Yet, despite our protestations, the truth, as reflected by the record, is somewhat different than our memories. The facts, as revealed by votes in Congress as well as the speeches and writings of opinion leaders of the time, are that during this period, we were often not just complicit in government's efforts to control and manage the economy—we conservatives were active participants.

In the past 20 years, many of us have battled to moderate or eliminate the most egregious of these programs and the artificial controls they place on free markets, but despite our successes, vestiges of the past remain. Some are found at the federal level, but some, including a few that even the federal government has given up on as bad ideas,

linger in the states.

A case in point is the so-called Certificates of Need Program (CON), which, in those states that require them including Florida, apply to part or all of the health care industry. They directly affect the cost and availability of health care services. This article briefly recounts the philosophy and history of certificates of need. A subsequent article will focus on CONs in Florida.

Why would a state voluntarily keep a program that has been so much of a failure that its parent, the federal government, disowned it?

Its History

In the late 1960s and early 70s, rising health care costs were becoming a serious concern. The market demand for services was increasing, as was the cost of providing those services. This was in part due to the advent of governmentally underwritten health care programs for the elderly and the poor, and in part due to the increasing availability of employer-provided health care benefits. Concepts such as managed care were all but unknown. In addition, there was in place an insurance (government and private) payment scheme known as retrospective cost reimbursement, which guaranteed providers would be paid on a cost-plus basis. That is to say, providers essentially were guaranteed to be paid for everything they did at the price they determined.[1] And following the iron law of economics that says, "People will do what you pay them to do and the more you pay them, the more they will do," providers nationwide responded by offering ever-increasing levels of care and by expanding their facilities.

As the problem of increasing costs deepened and began to be labeled a crisis, policymakers in the state capitals and in Washington, D.C., scrambled to develop some solution that would control costs yet not appear to impact health care entitlement programs. Much debate and many studies were produced suggesting one course or another, but the plan that went the furthest was called certificates of need. It was a classic bureaucratic rationing and allocation scheme and after being endorsed by the American Hospital Association in 1968, this plan began to gain acceptance. In 1970, New York was the first to adopt it as law,[2] and once part of the law in that bellwether state, the concept spread. In 1974, the federal government embraced the idea and language was added to Section XV of the Public Health Services Act that provided "incentives" for the states to enact such a program.[3]

Needless to say, the federal government's incentives for states to adopt certificates of need legislation were in the nature of a godfather offer; the states couldn't refuse except at the risk of losing federal funds. So one by one, the states

complied, especially after 1979 when Congress amended the 1974 Act to tighten the compliance requirement.[4]

In short, certificates of need programs were intended to maintain and enhance the quality of care and to control health care costs in local communities. They were to do this by promoting a governmentally defined and overseen "rational distribution" of certain health care services. In practical terms, this meant limiting the number of health care providers offering identical services within a given market. To achieve this, procedures were put in place mandating that health care facilities seeking to initiate or expand services must get state approval. Generally speaking, approval was required before a facility or provider could initiate projects requiring capital expenditures above a certain dollar amount, and before they could introduce new services, expand existing services, or increase the number of beds.[5]

Its Objectives

Although the individual state programs varied, seven objectives applied within the general definition given above. The certificates of need application and review process would do the following:

- Ensure the presence of high-quality and appropriately distributed services; these would provide equal access for consumers and would allow health care providers access to sufficient manpower.
- Encourage health care facilities and providers to develop long-range operational and capacity plans based on local community health care needs.
- Require considerations of personnel and financial feasibility as well as need in the development of the long-range plans.
- Encourage the development of affordable and accessible health services to all areas of a state.
- Encourage the consideration of more cost-effective strategies through mandating a thorough review of alternative services.
- Promote the sharing of services between facilities and providers, especially in rural areas, where operational and administrative costs could threaten facility survival.
- Offer the public a forum for input regarding needs and desires prior to establishing or expanding health care facilities and services.[6]

Its Results

With the federal mandate in place and the states falling into line and adopting CONs, the promoters of the scheme sat back and waited for the expected positive results. But they never came. Despite all the good intentions and despite the federal government strengthening the role of state authorities in the late 1970s, it was clear by the early 1980s that the design was not working. Not only were costs failing to come down as a result of CON reviews by health care planning bureaucrats, but they were increas-

ing. In fact, it seemed that the only tangible products of the certificate mandate were:

- The creation and staffing of new taxpayer funded bureaucracies.
- Expensive and time consuming application processes (the costs of which were, of course, passed on to consumers).
- Local community dissatisfaction with health care planners who were often far away and perceived as insensitive to local needs and whose decisions had negative impacts on local health care availability.[7]

So profound and complete was the failure of the certificates of need plan that in 1983, Lawrence D. Brown, writing in the *Journal of Health Politics, Policy and Law,* said,

> In searching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering health care costs. CON has elicited a remarkable evaluative consensus—that it does not work."[8]

Brown's comment reflected more than just a simple failure of a bureaucratic solution. It also came at a time when radical changes were beginning to take place within the health care industry.

First change. The first change was that, gradually, both private insurers and government began to realize that the retrospective cost reimbursement plan was both inefficient and wasteful. They looked for a new model and what emerged was "prospective reimbursement," which, in part, we know today as diagnostic related groups (DRGs). These, in turn, helped launch the era of managed care. Under prospective reimbursement, a set sum is paid to a provider based on a given condition regardless of the number of tests or procedures. It is a plan that puts a premium on efficiency of treatment in its reward structure rather than the quantity of treatment.[9]

Second change. The second change was one of definition, and it owes its birth to the change in the payment paradigm and not to any CON process, however defined. Prior to the mid-1980s, measuring success in the health care industry was akin to the way Detroit measured success before the oil crisis of the 1970s—the bigger and flashier, the better. In health care, this meant the latest tools, the most tests, the more procedures performed. But in the 80s, as with automobile in the 70s, the criteria for measuring success changed. Auto makers had begun concentrating on efficiency and safety at the expense of fins, chrome, and raw gas-guzzling horsepower. In like manner, so health care providers began to focus on outcomes of their services as the amounts paid them became standardized. The focus that had been quantity became quality.[10]

Changes

Congress did not address whether to keep certificates of need until 1986, regardless of the fact that the verdict on CON requirements was in as early as 1983, and regardless that the economic structure of health care was undergoing profound change. But when it did, with the 1980s spirit

of market deregulation running at flood tide, the mandate was repealed. States were set free to do as they pleased. They could keep their certificates programs if they chose, but they did not have to.[11]

The CON scheme had been a federal mandate that by every measure failed to achieve its central goal. Given that, the reader might assume that, once freed from the requirement, the states would have rushed to eliminate the program, as they did when the federally mandated 55 mph speed limit was dropped.

However, in this case they did not. Though some states did drop the program in favor of a free market approach to health care, only 14 states had done so by 1999, and one that initially did (Texas) reenacted its law. Meanwhile, 36 enacted few or no reforms, thus opting to cling to some form of certificates of need.[12] This happened despite the fact that there has been ample opportunity for a full discussion of the program's worth. For example, in 1998 alone some 230 bills were filed in state legislatures nationally to severely limit or outright abolish the program.[13]

The question, then, is "why?" Why would any state given the opportunity to unleash the benefits of the free market in the important field of health care choose not to do so? And why would any state voluntarily keep a program that has universally been deemed a failure—so much of a failure that its parent, the federal government, disowned it?

In searching for this answer, it is useless to examine the reasons given by legislators who have opposed the changes. Their reasons run on a continuum from wrong to ridiculous. As compiled by Patrick J. McGinley for a study published in the *Florida State University Law Review*, among the justifications given have been, "curbing 'excessive competition,' solving a 'moral hazard,' rectifying 'inadequate information,' and eliminating 'inefficient incentives'."[14] If these have any meaning in the real world, it is difficult to ascertain what it may be, and if they are invalid, then what is behind them? What is, or are, the real reason(s) why this failed program has proved so durable and so difficult to eliminate?

The answers, of course, are money and the simple, monopolistic desire to restrain trade and increase profits by restricting one's competitors. Or as Clark Havighurst somewhat more delicately put it in an article on CONs in the *Wake Forest Law Review*, "avoidance of 'duplication' is of course consistent with a cartel's preference for minimizing competition."[15] Simply put, then, certificates of need survive because the large, well-heeled hospitals—including some run by state governments themselves such as wealthy university teaching hospitals—and hospital industry groups that are often dominated by these big players have seized upon the excuse provided by the "public interest" component of CON laws. These laws and the expensive, time-consuming regulations they prescribe allow them a

legal, pseudo-public interest way to restrict health care commerce and, in some cases, cripple or eliminate competition from what they see as "their" market.

If, for example, a rival provider desires to implement or expand services that might compete with an established operation, the "have" provider can argue in the name of the "consumer" that to allow the "have not" applicant to put in place such "duplication" would raise costs and harm the public. They can argue this despite any reasonable interpretation of market theory, which holds that competition invariably works to increase efficiency and to improve the quality of service to the consumer, and results in lower costs. And they typically argue this through paid professional lobbyists who pose as spokespersons for a concerned public. These same lobbyists, often assisted by campaign cash, influence legislators to keep certificates of need in place lest the consumer be damaged.

Certificates of need continue to exist primarily for the benefit of wealthy and powerful providers and interest groups.

The lobbyists, the large well-established providers and provider groups have little of the public's interest in mind. They have their own interests in mind. Proof of this can be found in those states where the program has been dropped. A study by Christopher Conover and Frank Sloan of Duke University, which examined the experiences of states that had dropped CON requirements, found that no ill effects resulted. In fact, the opposite was true. When deregulation went into effect, per capita health care spending dropped and the quality and availability of service rose, thus providing a benefit to consumers. By contrast, they found that in those states that continued to require CONs, the effect of the regulations on per capita spending was not significant, nor did it work to increase availability or quality. Hence, there was little or no benefit to consumers. What was significant in those states retaining CONs, though, was the effective stifling of competition and the raising of existing providers' profits.[16]

Taking into account the above, it clearly seems past time for certificates of need to be abolished. They have failed. They do not benefit the consumer of health care with lower costs, increased quality, or enhanced availability of services. They continue to exist primarily for the benefit of wealthy and powerful providers and interest groups who mask their true motives by claiming that they are acting in the name of the "public good."

Peter Doherty is a senior policy analyst at The James Madison Institute and may be contacted via e-mail at peterd@jamesmadison.org.

Endnotes

[1]Cook, David A. Testimony before State of Georgia Joint House and Senate Health Committee, September 2, 1997.

[2]Blaufeux, Peter. *The Certificate of Need Process*. New York: Peter Blaufeux AIA Architects, 1999.

[3]McGinley, Patrick John. "Beyond Health Care Reform: Reconsidering Certificates of Need Laws in a Managed Competition System." Tallahassee, Fla.: *Florida State University Law Review*, 1995.

[4]Ibid.

[5]Cauchi, Dick. *Certificate of Need Laws: A State Legislative Survey*. Denver, Colo.: National Council of State Legislatures, 1999.

[6]State of Montana. *Certificate of Need Program Overview*. Helena, Mont.: Health Policy and Services Division, Montana Department of Public Health and Human Services, 1999.

[7]Ibid.

[8]Brown, Lawrence D. "Common Sense Meets Implementation: Certificate of Need Regulation in the States." *Journal of Health Politics, Policy and Law*, No. 8, 1983.

[9]Ibid.

[10]Ibid.

[11]Ibid.

[12]Ibid.

[13]Ibid.

[14]Kaplan, Mark E. "An Economic Analysis of Florida's Hospital Certificate of Need Program and Recommendations for Change." Tallahassee, Fla.: *Florida State University Law Review*, 1991.

[15]Havighurst, Clark C. "Regulation of Health Facilities and Services by 'Certificate of Need.'" Charlottesville, Va.: *University of Virginia Law Review*, 1973.

January/February 1996: Health Care

Ending the CON Game

by Michael D Tanner

Last year's defeat of the Clinton health care plan was a major blow for the idea of central planning in health care. But the idea that government bureaucrats should manipulate the medical marketplace persists. Nowhere is that more apparent than in state Certificate-of-Need programs.

Certificate-of-Need (CON) is a program under which health care providers must obtain state regulatory approval before they can make capital expenditures or offer new services. CON was originally imposed on the states by Congress as part of the 1974 National Health Planning and Resources Development Act. That law required every state to adopt CON procedures or lose federal health funding. Eventually, every state except Louisiana complied. Congress realized the failure of CON and repealed the requirement in 1982. Since then, 12 states have repealed CON programs and 17 others have removed CON requirements for hospitals.

Certificate-of-Need is based on the dubious economic theory that increased supply and competition will increase prices. At one time, there might have been some justification for the idea. At the time CON was developed, federal Medicare and Medicaid reimbursement policies, traditionally a driving force behind health care price increases, were based on a "cost-plus" calculation, meaning that providers could recover their full costs--no matter how high. That virtually eliminated price-based competition from the medical marketplace. However, Medicare and Medicaid no longer reimburse on a "cost-plus" basis. Since 1983, the government has reimbursed on a fixed-price basis (the DRG system). In addition, other third-party payers have become increasingly sensitive to health care costs. As a result, price competition among providers has increased dramatically.

Today, there is no evidence that CON reduces medical costs. In fact, there is considerable evidence that CON increases the cost of health care. It does so in three ways:

1) Administrative costs

The CON program itself imposes substantial costs on both health care providers and the government. Since its inception, federal and state governments have spent more than $1 billion administering the program. For providers, preparing and defending a CON application can be a time-consuming and expensive process. Needless to say, the extra cost is later passed along to consumers.

2) Lack of competition

CON requirements erect barriers to market entry, thereby reducing competition among health care providers. In effect, existing providers are granted a monopoly. Providers frequently attempt to use the CON process to obstruct would-be competitors. The impact of entry barriers is made even worse because the new provider seeking to enter the market is often more innovative and cost-effective than are established providers. Some health care economists estimate that CON barriers to market entry increase hospital costs by as much as 5 percent.

3) Shortages

Where CON requirements have produced a shortage of a particular health care service, prices for those services that are available are certain to rise. At the same time, consumers may be forced to shift to alternative services that are often more expensive. For example, a shortage of nursing home beds may lead to longer stays in acute care hospital facilities.

The Federal Trade Commission estimates that CON regulations increase the cost of hospital care nationwide by more than $1.3 billion annually.

Certificate-of-Need programs also reduce access to health care for those who need it most. In particular, public hospitals serving the inner-city poor often lack the legal and political resources necessary to compete for technology in a CON environment. There is even evidence that CON restrictions may ultimately lead to higher patient mortality.

It is time to realize that Soviet-style central planning is as big a failure in health care as in all other aspects of the economy. States should repeal their CON requirements.

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Michael D Tanner is director of health and welare studies at the CATO Institute in Washington, DC.

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JOINT HOUSE AND SENATE HEALTH COMMITTEES HEARINGS ON CERTIFICATE OF NEED LAWS (STATE OF GEORGIA)

TESTIMONY OF DAVID A. COOK DIRECTOR OF GOVERNMENT RELATIONS MEDICAL ASSOCIATION OF GEORGIA

September 2, 1997

Thank you Chairman Middleton and Chairman Childers for holding these hearings on this most important issue and for providing me with the opportunity to speak to you and the Committee members from the physicians' perspective. My name is David Cook and I represent the Medical Association of Georgia comprised of some 8,200 Georgia physicians.

The Medical Association of Georgia supports substantial reform of Georgia's Certificate of Need laws. Our position is based on a fundamental premise: that competition in a free and fair market is the best way to achieve quality health services at the lowest possible cost.

Certificate of Need laws were enacted in 1979 to restrain the cost of hospital and other health care services by regulating the number of facilities that may be built and the type of services that may be offered. In general, these government-sanctioned barriers have not been effective in restraining costs or even hospital investments. Because those with certificates are the only players in the market, they are not pressured to deliver high quality care at the lowest price. Basic economic principles indicate that artificial barriers on competition increase costs.

The fact that Certificate of Need laws have not worked is confirmed in the various studies already mentioned. Further evidence of the dissatisfaction with CON regulations is seen in the national trend to repeal such laws. Perhaps the strongest evidence that CON regulations are not working is found in the testimony you just heard: that Georgia's hospitals are operating at 55% excess capacity. It is rare that artificial restraints on competition benefit the consumers, our patients.

Even if you believe that Certificate of Need laws were appropriate two decades ago, the reasons underpinning enactment of the laws are no longer relevant in today's health care market. Let me give you three examples of how dramatically the health care market has changed in the past 20 years.

First, CON laws were enacted at a time when there was very little competition in the health care market. The same cannot be said of today's healthcare marketplace where competition is fierce.

Second, dramatic changes in reimbursement methodologies have turned provider incentives upside down. In 1979, hospitals were paid on a "cost plus" basis. This guaranteed that hospitals would be paid for every service provided and encouraged overutilization of services. The more the better. Today, hospitals are paid by "Diagnostic Related Groups" (DRG's) which is a set sum for the diagnosed condition regardless of the number of tests or procedures performed. The fewer the services the better.

Finally, we are in the midst of redefining "quality" as it relates to health care. Where hospitals

once measured quality by the number of procedures performed or the availability of the latest technology, quality is now being measured by outcomes achieved.

In sum, the health care market is not what it was in 1979.

The Medical Association of Georgia supports repeal of certificate of need laws except in a few narrow areas that deserve special consideration. The first is in the area of long term care facilities. Unlike many other areas of health care, Medicaid currently pays 80%+ of all nursing home services making this area very nearly a mini "single payor" system. As a result, nursing homes have not historically faced the same kind of competition that hospitals face. Thus, market forces will not work and a different strategy, including the possibility of retaining CON for nursing homes, should be considered.

We also appreciate the important role that caring for the indigent population has in this debate. I would like to take this opportunity to remind you that physicians, not hospitals, treat and care for patients. It is the physician that is called at 3:00 in the morning to come to the hospital to treat the patient. It is the physician who provides his services, often free of charge.

In a recent survey conducted by the Medical Association of Georgia, our members said that they incurred, on average, $50,000 in charity care (care for which there was no expectation of compensation) per year and some $91,000 in bad debt (services for which there is an expectation of compensation but an inability to collect) per year.

Recent reductions in Medicare and Medicaid reimbursement rates have exacerbated the problem. In FY 1996, the Governor proposed, and the General Assembly agreed, to cut Medicaid's physician reimbursement rates by some $21.5 million per year. Last year (FY 97), physicians suffered an additional $7 million in cuts. That is an annual reduction of $29 million in payments to Georgia physicians for the same level of services previously provided. **Physicians' services, which account for the smallest percentage (17%) of provider expenditures, took a whopping 36% of all cuts to Medicaid providers.**

In addition, the Balanced Budget Act of 1997 will squeeze some $5.8 billion from physician Medicare services over the next five years. The real kicker is that Medicaid reimbursement rates are tied to Medicare rates. (Currently Medicaid pays physicians 87% of the Medicare reimbursement rate known as RBRVS). Since Medicaid reimbursement rates for physician services are directly tied to Medicare rates, the new cuts in Medicare will result in even further reductions in Medicaid reimbursement rates.

Traditionally, physicians have shifted the costs of providing indigent care to the private sector. With the onslaught of managed care, physicians are becoming less able to shift these costs to private payors. Hospitals have an Indigent Care Trust Fund to help defray the costs of indigent patients, but physicians have no similar funding mechanism. The problem of providing physician services to indigents has now reached crisis proportions.

Thus, when looking at the question of indigent care, I would urge you to keep in mind who actually provides the care and treatment of indigent patients. I would also suggest that if the market continues to ratchet down physician reimbursements, some accomodation will be necessary to assure continued care for the indigent population.

On a final note, I want to underscore the points made by Dr. Tedesco and Dr. Skelton related

to Graduate Medical Education. Prior to this year, Graduate Medical Education was funded through Medicare. Recent federal legislation has changed this and new sources of funding are necessary to continue training doctors. The Senate is currently considering ways to continue funding medical education here in Georgia.

But the problem is not only with access to funds. Medical education, by definition, requires access to patients. It has been said that it is easier to obtain a certificate of need if you can demonstrate a contribution to medical education in Georgia. It has also been said that concentration of specific types of services makes it easier to train residents. Yet these CON solutions do not address a real problem: that is, managed care companies are driving patients from teaching institutions because they do not provide the cheapest care. A more realistic approach wouls be to require all managed care companies to make some commitment to medical education, whether in the form of monetary contributions, a guaranteed supply of patients, or both.

I know I have used the time allotted and so I'll stop here and answer any questions you or the committee may have. Once again, I thank you for the opportunity to appear before you.

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INTELIVIEW RELESS

ALASKA STATE HOUSE OF REPRESENTATIVES

Interim Address:
119 N. Cushman, Suite 211
Fairbanks, AK 99701
(907)-456-5081
Fax# (907)-456-8245

Session Contact:
(907)-465-3719
FAX# (907)-465-3258
State Capitol
Room 102

REPRESENTATIVE JOHN COGHILL

HB 407 Certificate of Need
Sponsor Statement

In trying to preserve the free enterprise system, I will do all that I can to protect our open market and the consumer's choice. This bill is an attempt to do this in the world of health care.

Under the current state statutes, if a health care provider in Fairbanks or the Mat-Su Borough wanted to build or supply services over $1 million dollars worth, they would have to obtain a Certificate of Need. In applying for that certificate of need they would have to prove to the government that a proposal would not adversely affect other health care facilities. This puts the government in charge of who can deliver health care in any area. I would rather see the customer and the health care providers have a greater choice in the market dynamics.

I don't believe that by eliminating the CON requirement for larger Alaskan communities there will be large influx of new medical facilities. This may have been true when the federal government subsidized CON programs, but the federal CON law was repealed in 1986. Since the repeal of the federal law, 14 states have repealed CON's. Another ten states have eliminated CON requirements for acute care facilities and additional nine states do not require CON's for ambulatory surgical centers.

More ambulatory surgical centers in Fairbanks would not, in my opinion, mean less business for existing facilities. It could mean however, more choices in providers and that fewer Fairbanksans may have to travel to Anchorage or the lower forty-eight for a medical procedure.

According to the attached *Heartland* article, in 1996 the Federal Trade Commission estimated that CON regulations increased the cost of hospital care nationwide by more than $1.3 billion annually.

This legislation will encourage competition in the larger Alaskan communities where the population would support competition while protecting the fragile balance of health care services in the smaller Alaskan communities.

Representative_John_Coghill@LEGIS.state.ak.us

ALASKA STATE HOUSE OF REPRESENTATIVES

Interim Address:
119 N. Cushman, Suite 211
Fairbanks, AK 99701
(907)-456-5081
Fax# (907)-456-8245

Session Contact:
(907)-465-3719
FAX# (907)-465-3258
State Capitol
Room 102

REPRESENTATIVE JOHN COGHILL

CSHB 407(HSS) Sectional

Section 1. Requires a certificate of need for skilled nursing facilities and psychiatric hospitals in areas with a population of 55,000 or more if there is an expenditure of $1 million or more for construction of a facility, alteration of the bed capacity, or the addition of a category of health services.

Eliminates the requirement of a Certificate of Need for construction, alteration of bed capacity, or addition of a category of health services when the facility is located in a municipality of 55,000 or more.

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

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

Section 4. Requires the department to set a time limit by which public hearings must be held.

Requires the department to approve or deny an application within 120 days of the date the department determined the application was complete.

Section 5. Places all certificate of need applications under the same standards of review that currently exist for nursing home beds. The original CON standards under AS 18.07.043 were for nursing homes and nursing beds. As the CON requirements for other expenditures were adding into state the standard of review were broadly apply to certificates of need relating to non-nursing home beds and services under AS 18.07.041. This change gives a more definitive standard for the applicants to follow.

Sections 6 Thru 10. Technical changes required under Section 5.

Section 11. Repeals the broad standard of review in AS 18.07.041.

Section 12. Applicability of new statute is limited to CON applications filed on or after the effective date.

Section 13. Has an immediate effective date.

TEXT OF AS 18.07.041 TO BE REPEALED IN CSHB 407(HSS)

Sec. 18.07.041. Standard of review for applications for certificates of need relating to non-nursing home beds and services.

The department shall grant a sponsor a certificate of need or modify a certificate of need that authorizes beds other than nursing home beds or that is for a health care facility other than a nursing home if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of citizens of this state.

22-LS1389\F
Lauterbach
3/21/02

CS FOR HOUSE BILL NO. 407( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES COGHILL, James, Scalzi, Dyson

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the certificate of need program; and providing for an effective**
2 **date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** AS 18.07.031(a) is amended to read:
5 (a) Except as provided in (c) of this section, a person may not make an
6 expenditure of $1,000,000 or more for any of the following unless authorized under
7 the terms of a certificate of need issued by the department:
8 (1) construction of a **skilled nursing** [HEALTH CARE] facility **or**
9 **psychiatric hospital**;
10 (2) alteration of the bed capacity of a **skilled nursing facility or**
11 **psychiatric hospital or addition of nursing beds or psychiatric beds to a** health
12 care facility; [OR]
13 (3) addition of a category of health services provided by a **skilled**
14 **nursing facility or psychiatric hospital; or**

(4) with respect to facilities and beds that are not subject to (1) - (3) of this subsection, construction of a health care facility**, alteration of the bed capacity of a health care facility, or addition of a category of health services provided by a health care facility, if the health care facility is located in the unorganized borough or in an organized borough with a population of less than 55,000 at the time of commencement of activities, according to the latest reliable data approved by the Department of Community and Economic Development**.

* **Sec. 2.** AS 18.07.031(c) is amended to read:

(c) Notwithstanding (a) of this section, a person who is lawfully **authorized to operate** [OPERATING] a health care facility [THAT IS AN AMBULATORY SURGICAL FACILITY] at a site may make an expenditure of any amount in order to **replace the facility at the same site or** relocate the services of that facility to a new site in the same community without obtaining a certificate of need as long as neither the bed capacity nor the number of categories of health services provided at the new site is greater **and no new category of health services is provided**. However, notwithstanding the expenditure **thresholds, population thresholds, and other provisions of** [THRESHOLD IN] (a) of this section, a person may not use the site from which the health care facility relocated for another health care facility unless authorized under a certificate of need issued by the department.

* **Sec. 3.** AS 18.07.035 is amended to read:

Sec. 18.07.035. Application and fees. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision **about whether to issue the certificate of need** [UNDER THIS CHAPTER]. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation. **The department shall, by regulation, set a time limit by which the department shall determine whether an application submitted under this section is complete and contains all of the information the department requires to reach a decision about whether to issue the certificate of need.**

* **Sec. 4.** AS 18.07 is amended by adding new sections to read:

Sec. 18.07.037. Public hearing required. Except as provided in

1 AS 18.07.071 the department shall hold a public hearing within a reasonable time
2 after determining that an application under AS 18.07.035 is complete. By regulation,
3 the department shall establish
4 (1) a time limit by which a public hearing required under this section
5 shall be held; and
6 (2) procedures for conducting a public hearing held under this section.
7 **Sec. 18.07.039. Time limit for decision on application.** Based on the
8 standards for review under this chapter, the department shall, within 120 days after
9 determining that an application under AS 18.07.035 is complete, approve or deny the
10 application.
11 * **Sec. 5.** AS 18.07.043 is amended to read:
12 **Sec. 18.07.043. Standard of review for applications for certificates of need**
13 **<u>and applications to modify certificates of need</u> [RELATING TO NURSING**
14 **HOMES AND NURSING HOME BEDS].** (a) The department shall develop
15 review standards for an application for a certificate of need, or for a modification of a
16 certificate of need, issued under this chapter [FOR A HEALTH CARE FACILITY
17 THAT IS A NURSING HOME OR HAS NURSING HOME BEDS].
18 (b) **<u>When determining whether to approve an application for a new</u>**
19 **<u>certificate of need or to modify an existing certificate of need</u>** [IN DEVELOPING
20 THE REVIEW STANDARDS UNDER (a) OF THIS SECTION], the department
21 shall consider whether
22 (1) a public process and existing appropriate statewide, regional, and
23 local plans were included in planning and designing the **<u>project</u>** [ADDITIONAL
24 NURSING HOME BEDS OR THE HEALTH CARE FACILITY];
25 (2) the **<u>project will meet</u>** [ADDITIONAL NURSING HOME BEDS
26 OR THE HEALTH CARE FACILITY MEETS] minimum required use rates for **<u>the</u>**
27 **<u>proposed services without causing the</u>** [NEW NURSING BEDS, AND THE
28 EFFECT ON] use rates for existing **<u>providers of the services to fall below minimum</u>**
29 **<u>required use rates</u>** [NURSING HOME BEDS];
30 (3) the **<u>project</u>** [ADDITIONAL NURSING HOME BEDS OR THE
31 HEALTH CARE FACILITY] demonstrates consideration of the community, regional,

1 and statewide needs [FOR NEW NURSING HOME BEDS];
2 (4) the **project** [ADDITIONAL NURSING HOME BEDS OR THE
3 HEALTH CARE FACILITY] meets the minimum **standards of the department that**
4 **are designed** [NUMBER OF NEW NURSING BEDS THAT SHOULD BE
5 REQUIRED IN A FACILITY] to ensure efficiency and economies of scale;
6 (5) the **project** [ADDITIONAL NURSING HOME BEDS OR THE
7 HEALTH CARE FACILITY] demonstrates the proposed service will provide a
8 quality of care equivalent to existing community, regional, or statewide services;
9 (6) the **project** [ADDITIONAL NURSING HOME BEDS OR THE
10 HEALTH CARE FACILITY] demonstrates financial feasibility, including long-term
11 viability, and what the financial effect will be on consumers and the state; and
12 (7) the sponsor has demonstrated cost effectiveness through
13 considering the availability of appropriate, less costly alternatives of providing the
14 services planned.
15 (c) The department shall grant a sponsor a certificate of need or modify a
16 certificate of need [THAT AUTHORIZES NURSING HOME BEDS OR THAT IS
17 FOR A HEALTH CARE FACILITY THAT IS A NURSING HOME] if the
18 department finds that the sponsor meets the standards established in or under this
19 chapter.
20 * **Sec. 6.** AS 18.07.071(b) is amended to read:
21 (b) The department may grant a sponsor a temporary certificate for the
22 temporary operation of a category of health service if the sponsor shows by affidavit
23 or formal hearing
24 (1) the necessity for early, immediate, or temporary relief; and
25 (2) adverse effect to the public interest by reason of delay occasioned
26 by compliance with the requirements of **AS 18.07.043** [AS 18.07.041, 18.07.043,] and
27 application procedures prescribed by regulations under this chapter.
28 * **Sec. 7.** AS 18.07.071(c) is amended to read:
29 (c) A temporary certificate granted under (b) of this section does not confer
30 vested rights on behalf of the applicant. The department shall impose those special
31 limitations and restrictions concerning duration and right of extension that the

1 department considers appropriate. A temporary certificate may not be granted for a
2 period longer than necessary for the sponsor to obtain review of the action certified by
3 the temporary certificate under AS 18.07.051. Application for a certificate of need
4 **that will be reviewed** under **AS 18.07.043** [AS 18.07.041 OR 18.07.043] must
5 commence within 60 days **after** [OF] the date of issuance of the temporary certificate.
6 * **Sec. 8.** AS 18.07.081(c) is amended to read:
7 (c) A certificate of need shall be suspended if an accusation is filed before the
8 commencement of activities authorized under **AS 18.07.043** [AS 18.07.041 OR
9 18.07.043] that charges that factors upon which the certificate of need was issued have
10 changed or new factors have been discovered that significantly alter the need for the
11 activity authorized. A suspension of a certificate may not exceed 60 days. At the end
12 of this period or sooner, the department shall revoke or reinstate the certificate.
13 * **Sec. 9.** AS 18.07.081(d) is amended to read:
14 (d) A certificate of need may be revoked if
15 (1) the sponsor has not shown continuing progress toward
16 commencement of the activities authorized under **AS 18.07.043 within** [AS 18.07.041
17 OR 18.07.043 AFTER] six months **after the date** of issuance **of the certificate;**
18 (2) the applicant fails, without good cause, to complete activities
19 authorized by the certificate;
20 (3) the sponsor fails to comply with [THE PROVISIONS OF] this
21 chapter or regulations adopted under this chapter;
22 (4) the sponsor knowingly misrepresents a material fact in obtaining
23 the certificate;
24 (5) the facts charged in an accusation filed under (c) of this section are
25 established; or
26 (6) the sponsor fails to provide services authorized by the terms of the
27 certificate.
28 * **Sec. 10.** AS 18.07.111(2) is amended to read:
29 (2) "certificate" means a certificate of need issued by the department
30 under **AS 18.07.043 or 18.07.071** [AS 18.07.041, 18.07.043, OR 18.07.071];
31 * **Sec. 11.** AS 18.07.041 is repealed.

1 * **Sec. 12.** The uncodified law of the State of Alaska is amended by adding a new section to
2 read:
3 APPLICABILITY. AS 18.07, as amended by secs. 1 - 11 of this Act, applies to
4 applications for certificates of need that are initially filed on or after the effective date of this
5 Act.
6 * **Sec. 13.** This Act takes effect immediately under AS 01.10.070(c).

Tanana
Valley
Clinic

Family Medical Care
Since 1959

Memorandum

March 28, 2002

To: Legislators

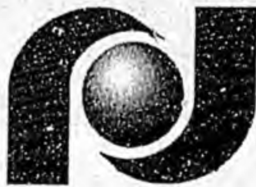
From: Brian Slocum BS

RE: Information Insights study of fiscal impact of revising CON

Attached you will find a copy of the study prepared by Information Insights, which reviewed the potential financial impact of revising the CON legislation on the State budget. The study makes the following points:

- **The promise of competition may reduce Medicaid costs prior to any new ambulatory surgery center (ASC) opening;**
- **Competition from a new ASC may reduce Medicaid costs during the initial year of ASC operation;**
- **During the third year after a change in the CON law, there is a potential for a change in Medicaid cost ranging from a savings of $20,000 to a possible increase of $190,000 with costs decreasing every year thereafter;**
- **The long-run effect of modifying the CON law and building an ASC in Fairbanks will be to reduce the State's Medicaid costs for outpatient services.**

Please feel free to contact me at (907) 459 – 3509 if you have any further questions.
Thank you.



information insights

212 Front Street, Suite 100
PO Box 73490
Fairbanks, AK
99707
(907) 452-2461

(907) 452-3143
brogers@infoinsights.com

March 25, 2002

To: Brian Slocum
Tanana Valley Clinic

From: Brian Rogers, Principal Consultant

Re: Impact of Certificate of Need Legislation

Executive Summary

Tanana Valley Clinic (TVC) is supporting legislation (SB 256 and HB 407) that would amend Certificate of Need (CON) requirements for construction of certain health care facilities in the State of Alaska. The immediate effect of the legislation would be to allow TVC to proceed with construction of an ambulatory surgical center (ASC) similar to that described in TVC's May 1999 Certificate of Need Application.

Information Insights, Inc., was retained to examine the potential economic impact of this legislation. This analysis focuses on the economic impact of opening a freestanding ASC in Fairbanks, paying particular attention to the specific concern that the ASC would increase Medicaid costs to the state of Alaska.

There is some potential for the promise of an ASC to reduce Medicaid costs prior to the ASC opening its doors.

There is the potential for the opening of the ASC to reduce Medicaid costs further for a short time, perhaps for one year from the time of opening.

There is the potential for Medicaid costs to increase for a time, beginning roughly one year from the time the ASC opens and lasting no more than five years. The additional Medicaid cost is likely to be no more than $200,000 dollars per year ($80,000 in costs to the state general fund[i]), and can not reasonably be expected to exceed $500,000 ($200,000 in costs to the state general fund) under any realistic circumstances. The additional cost is expected to decrease in every year after the first.

This period of increased Medicaid cost will end when Fairbanks Memorial Hospital either attracts sufficient numbers of additional outpatients to replace those who migrate to the ASC or reallocates its capital resources so as to most efficiently adapt to a reduced number of outpatients.

The long-run effect of opening an ASC in Fairbanks will be to reduce the Medicaid cost associated with any given level of outpatient services.

[i] Basic Alaska Medicaid costs are currently shared between federal funds (59.8 percent) and state general funds (40.2 percent).

Estimating the Impact of a Freestanding ASC on Medicaid Cost

Fairbanks Memorial Hospital (FMH) is currently the sole provider of outpatient surgical procedures in the Fairbanks market. The introduction of a freestanding ASC into the Fairbanks market has the potential to reduce prices charged for outpatient surgical procedures through competition with FMH.

The following discussion addresses concerns that the ASC would raise Medicaid program costs to the State of Alaska (hereafter referred to as the Medicaid cost argument). These conclusions are preliminary and are based on financial information contained in the separate CON applications submitted by TVC and Fairbanks Memorial Hospital (FMH) in May 1999. The financial information contained in these documents allows us to estimate the Medicaid cost to the state of patients treated at FMH, and to estimate the change in this cost when some number of the hospital's outpatients are treated instead at a freestanding ASC.

The Medicaid cost argument is based on the formula[i] used to determine the amount that a hospital shall be reimbursed for services provided to Medicaid outpatients. This formula is explained in detail in Appendix A. The state multiplies all Medicaid charges submitted by the hospital by a percentage rate and pays the hospital the resulting amount. The percentage rate is based on the outpatient cost-to-charges ratios (reported in the hospital's Medicare Cost Report) of multiple cost centers within the hospital. Thus the amount that the hospital is reimbursed for services provided to Medicaid outpatients is roughly the cost of the services. The numerator of each cost-to-charges ratio may include both fixed costs (which do not vary in the short run with the number of patients treated) and variable costs (which do vary with the number of patients treated).

The Medicaid cost argument is as follows: If the hospital loses outpatients to the ASC, the charges in the denominator of each cost-to-charges ratio will be reduced by some percentage, and the variable costs in the numerator will be reduced by roughly the same percentage. Because of the existence of fixed costs in the numerator, the effect of losing outpatients to the ASC will be to raise the percentage rate. Thus the state will be required to pay a higher percentage of every dollar the hospital bills.

Understanding the mechanism underlying the Medicaid cost argument, we can make the following observations:

First, any immediate reduction in hospital outpatient charges resulting from outpatients migrating from the hospital to the ASC will have no effect on the percentage rate until the hospital updates the cost-to-charges ratios in its next Medicare Cost Report; the full effect on the percentage rate of outpatients migrating from the hospital to the ASC will not be realized until after the first full cycle of the Medicare Cost Report following the introduction of the ASC.

Second, the appearance of additional outpatients will mitigate the effect of outpatient migration on the percentage rate. As the population increases and ages, more outpatient services will be required. Over time, these new patients may replace those who migrated from the hospital to the ASC. This will ultimately return the percentage rate to pre-ASC

levels. If, for whatever reason, the hospital finds that it cannot attract additional patients quickly enough to justify the fixed costs previously attributed to outpatient services, it has the option of reassigning fixed costs. For example, an outpatient operating room could presumably be converted to an inpatient operating room in the event that reduced demand for outpatient services at the hospital persists.

The Medicaid cost argument is valid only for a well-defined period of time, during which hospital Medicaid outpatient charges are reduced relative to fixed costs attributable to Medicaid outpatients. The limitations of the argument can be seen in the following periods:

Period 0 (Construction).

Given the uncertainty in the situation, no project construction will begin before May 2003, so no operational business could be in place before Summer 2004. During this period, which will encompass the next two state fiscal years — FY03 and FY04 — FMH will lose no business to the ASC and therefore Medicaid costs will not increase by the mechanism described in the Medicaid cost argument. There is, however, some possibility that FMH may reduce prices after it is certain the ASC will be built but before it opens. In this event, Medicaid costs will initially decrease because the same percentage rate will be applied to reduced charges. Once the price reduction is fully reflected in the percentage rate, Medicaid costs will return to original levels because the same percentage will be taken both from the denominator of the percentage rate and from the Medicaid charges that are multiplied by the percentage rate[ii].

Period 1 (Immediately after the ASC opens).

Following the reasoning set forth in Period 0, there will be a period immediately after the ASC opens but before any changes in price or utilization patterns can be fully reflected in the cost-to-charges ratios reported in FMH's Medicare cost report. During this period, the percentage rate applied to hospital Medicaid outpatient charges will remain at its existing level (end of period 0). If FMH reduces prices further, Medicaid costs for those outpatients remaining at the hospital will decrease. Medicaid cost will also decrease for virtually all outpatients migrating from the hospital to the new ASC.

Period 2 (Near Term).

Once changes in price and utilization patterns affected by the introduction of the ASC have been established and are fully reflected in the cost-to-charges ratios reported in FMH's Medicare cost report, Medicaid costs in the Fairbanks market may for a time be greater than or less than what they would have been had the ASC not been introduced. This is the only period in which the Medicaid cost argument is tenable.

The change in Medicaid cost will depend on several factors, principally:

1. The proportion of hospital outpatient costs that are fixed costs.
2. The extent to which lower prices attract additional patients.
3. The percent of Medicaid patients who elect to be treated at the ASC.

4. The difference in Medicaid cost for comparable complete treatments at FMH and at the ASC.

The change in Medicaid cost is estimated in a number of scenarios in Appendix B. The most liberal scenario estimates an increase in Medicaid cost of $475,000 for one year. Of this amount, the State of Alaska would be responsible for approximately $190,000 in state general funds. Two other scenarios, each imposing a degree of reason on this upper bound in a slightly different way, estimate an increase in Medicaid cost of $150,000 for one year ($60,000 in costs to the state general fund). Under one scenario specified in Appendix B, Medicaid costs decrease by more than $50,000 ($20,000 in savings to the state general fund).

Period 3 (Long Term).

Medicaid costs may increase by the mechanism set forth in the Medicaid cost argument only so long as hospital outpatient cost-to-charges ratios remain higher than they would be in the absence of the ASC. Hospital outpatient cost-to-charges ratios may return to original levels in either of two ways, or in some combination of both:

1. Holding outpatient fixed costs at their original level, the hospital may attract additional patients to replace those migrating to the ASC. The hospital may attract additional patients immediately with lower prices, and the hospital may expect to attract its share of the growing market for outpatient surgery as the population increases and ages over time[iii].
2. The hospital may reassign fixed costs, thereby reducing the fixed costs attributable to outpatients and reflected in outpatient cost-to-charges ratios. The example of an outpatient operating room being converted to an inpatient operating room was offered earlier. If FMH is unable to attract additional outpatients to replace those migrating to the ASC and does not foresee being able to do so within a reasonable amount of time, it is only natural to expect the hospital to put its facilities to better use, rather than continue to devote resources to outpatients it does not have. In the long run, no costs are truly fixed. A side effect of the hospital's private profit-maximizing decision to allocate its capital resources efficiently is that outpatient cost-to-charges ratios will return to pre-ASC levels.

To summarize: Following the introduction of a freestanding ASC, there would be an initial period of adjustment in which Medicaid costs (relative to Medicaid costs in the absence of the ASC) will almost surely be lower (Periods 0 and 1). There will follow a period during which there is the potential for Medicaid costs to be higher as described in the Medicaid cost argument (Period 2). If additional outpatients are not forthcoming in sufficient numbers to justify the level of fixed costs devoted by the hospital to outpatient care, it is in the hospital's private interest to reassign fixed costs. The time required to attract sufficient numbers of additional patients, or the time required for the hospital to reorganize (whichever is shortest) limits the duration of Period 2, and the time during which there is potential for increased Medicaid costs, to probably no more than a few years. During period 2, the additional Medicaid cost is likely to be no more than $200,000 dollars per year ($80,000 in costs to the state general fund), and can not reasonably be expected to exceed $500,000 ($200,000 in costs to the state general fund)

under any realistic circumstances. The long-run effect of opening the ASC will be to reduce Medicaid costs for any given level of outpatient services. The reason is that Medicaid costs are generally lower for outpatients treated at an ASC as opposed to a hospital. Once hospital outpatient cost-to-charges ratios have stabilized at pre-ASC levels, the mechanism behind the Medicaid cost argument is finished and we are left with some number of Medicaid patients receiving treatment at the ASC instead of at the hospital at lower cost to the state.

Appendix A: Determination of Medicaid Outpatient Reimbursement Rates

I. ASC Medicaid Rates

Each ASC procedure falls into one of eight Medicare payment groups. Alaska Medicaid reimbursement rates are based on the Medicare ambulatory surgical center payment rates for federal fiscal year 2000 as set out in 65 Fed. Reg. 6380-6383. Separate rates are set for each of the eight payment groups and a regional wage index is applied. To determine the Medicaid rate. the Medicare rates from federal fiscal year 2000, already adjusted to the appropriate region, are adjusted annually by the adjustment factors in 7 AAC 43.683. This methodology is set out in 7 AAC 43.685(i).

II. Acute Care Hospital Medicaid Rates

Medicaid reimburses a hospital for a percentage of outpatient charges; the charges submitted by the hospital for Medicaid outpatient services are multiplied by a percentage rate and the State pays the resulting amount to the hospital. The hospital is bound by State and Federal laws to charge no more for Medicaid patients than it would to the general public. The percentage rate is a weighted average of the outpatient cost-to-charges ratios for each of the hospital's cost centers (excluding laboratory cost center) reported in the hospital's Medicare cost report; each cost-to-charge ratio is weighted by the Medicaid outpatient charges for each cost center, which are also found in the Medicare cost report. Specifically: The outpatient cost-to-charges ratio (OCCR) for each cost center is multiplied by the corresponding Medicaid outpatient charges (MAOPCHRG) to calculate the Medicaid outpatient costs (MAOPCOST) for each cost center. The Medicaid outpatient costs are summed over the cost centers and divided by the Medicaid outpatient charges, summed over the cost centers, to arrive at the percentage rate (PR).

1. $$PR = \Sigma((OCCR_i)(MAOPCHRG_i)) / \Sigma(MAOPCHRG_i)$$

$$= \Sigma(MAOPCOST_i) / \Sigma(MAOPCHRG_i)$$

The percentage rate (established using the hospital's Medicare cost report) is then multiplied by the hospital's Medicaid outpatient charges (billing) to determine the amount of reimbursement. This methodology is set out in 7 AAC 43.685(c).

Appendix B: Quantitatively Estimating the Period 2 Increase in Medicaid Costs

Fairbanks Memorial Hospital (FMH) in its CON application (May 1999) reported the following revenues and expenses for 1998:

Total Patient Revenues	$109,579,087
Outpatient Revenues	$ 39,407,379
Total Expenses	$ 82,029,812
Supplies (proxy variable cost)	$ 13,182,423
All Other (proxy fixed cost)	$ 68,847,389

Outpatient revenues are 36% of total patient revenues. Applying this percentage to expenses (costs), we arrive at the following estimates of outpatient share of costs:

Outpatient Total Cost	$29,499,971
Outpatient Variable Cost	$ 4,740,729
Outpatient Fixed Cost	$24,759,242

Total and outpatient revenues reported are gross, prior to deductions, and so can serve as a proxy for patient charges. A proxy for the percentage rate can then be calculated as $29,499,971 (outpatient costs) divided by $39,707,379, which equals 74.9%.

Medicaid gross patient charges are reported to be 13% of total gross patient charges (May 1999 CON application). Applying this percentage to outpatient charges, we estimate Medicaid outpatient charges to be 13% of $39,707,379, or $5,122,959.

Multiplying estimated Medicaid outpatient charges by our estimated percentage reimbursement rate, we estimate the cost to the state to be 74.9% of $5,122,959, or $3,834,996.

The effect of opening an ASC in the Fairbanks market is estimated in the following scenarios:

Scenario 1

This scenario should set the upper bound for the additional cost to the State.

The TVC CON application predicts total patient revenue (prior to any deductions) of about $4.5 million by the *third* year. We use this figure as an upper bound. Suppose that $4.5M reflects charges that are 20% less that pre-ASC hospital charges for comparable services. That $4.5M in ASC revenue would take away $4.5M divided by 0.8, or $5,625,000 from hospital outpatient revenues. Outpatient revenue, which we use as a proxy for charges, becomes ($39,407,379 - $5,625,000 =) $33,782,379.

Let's further suppose the hospital reduces its outpatient charges by 10% in order to compete with the ASC. So we have (0.9)($33,782,379) = $30,404,141. Overall, outpatient charges are ($30,404,141 / $39,407,379 = 0.77) reduced by 23%. Applying the same reduction to outpatient variable cost (0.77 * $4,740,729 = $3,657,634) and adding to the original fixed cost ($3,657,634 + $24,759,242) we obtain a new estimate for total outpatient costs of $28,416,877. The new percentage rate is estimated as new cost divided by new charges: $28,416,877 / $30,404,141 = .935.

If we assume (for simplicity, and also in the spirit of estimating an upper bound for additional Medicaid cost) that all Medicaid patients stay at the hospital, then outpatient Medicaid charges are reduced only by the 10% price reduction. Multiplying $5,122,959 by 0.9 we obtain new outpatient Medicaid charges of $4,610,663. Multiplying this by the percentage rate of approximately 0.935 we obtain new Medicaid cost of approximately $4,310,000. **The additional Medicaid cost would be $475,000 ($190,000 in costs to the state general fund).**

Scenario 2

The use of supply costs as a proxy for all variable costs gave a lower bound for actual variable costs. A more realistic estimate of actual variable costs might be three times supply cost, or roughly $39.6 million instead of $13.2 million. Making only this change and adopting all the other assumptions of Scenario 1, **the additional Medicaid cost would be $146,000 ($58,400 in costs to the state general fund).**

Scenario 3

Using the TVC ASC projected patient revenues of roughly $3.8M from the first instead of the third year of operation, and estimating some increase in total revenue (TVC and FMH combined) because of lower prices attracting additional patients so that FMH loses only half of ($3.8M divided by 0.8), and still assuming all Medicaid patients stay at the hospital, either

a) **the additional Medicaid cost would about $150,000 ($60,000 in costs to the state general fund)** if we estimate variable cost as $13.2 million as we did in Scenario 1, or

b) **Medicaid costs would be <u>reduced</u> by more than $50,000 ($20,000 in savings to the state general fund)** if we estimate variable cost as $39.6 million as we did in Scenario 2.

Scenario 4

A scenario, following from Scenario 3, in which Medicaid patients now leave the hospital for the new ASC at the same rate as all other patients, could allow us to reduce the additional cost still further or estimate a further cost saving.

Notes

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[i] Set out in 7 AAC 43.685(c).

[ii] The canceling of the percentage reduction in charges is not exact because of the averaging of the outpatient cost-to-charges ratios for multiple cost centers. Generally speaking, a price reduction, once fully accounted for in the percentage rate applied to Medicaid outpatient charges, will not affect total Medicaid cost. The intuitive reason for this is that Medicaid reimburses the hospital for Medicaid outpatient costs only.

[iii] The Alaska Department of Labor has recorded the aging trend in Alaska's population over roughly the past ten years and projects a continued aging trend for the next ten years. Because of the increased need for health care that accompanies aging, this aging trend, combined with modest annual increases in total population, should fuel increased demand for health care services, including outpatient surgeries and procedures, for at least the next ten years.

CONFIDENTIAL

Family Medical Care
Since 1959

Memorandum

March 28, 2002

To: Legislators

From: Brian Slocum

RE: Analysis of impact of eliminating CON in other states

Attached you will find a copy of 2 academic studies which reviewed the impact of eliminating CON legislation in other States. The 2 studies makes the following points:

- **CON laws increase hospital costs and increase hospital profits** (*Conover, page 466*);
- **CON laws cause a 21% increase in hospital spending and a 9% increase in other health care spending** (*Conover, page 471*);
- **There were no increase in costs in States that eliminated their CON's** (*Conover, page 458, 469, 478, and Mendelson, page 37*);
- **There was no decrease in hospital profits in States that eliminated their CON's**(Conover, page 466);
- **States with more stringent CON policies experienced higher patient mortality rates than those without these policies** (*Conover, page 477*).

Please feel free to contact me at (907) 459 – 3509 if you have any further questions. Thank you.

Certificate of Need Revisited

Certificate of Need programs can play an important role in managing health care, though not necessarily in the manner originally intended.

by Daniel N. Mendelson and Judith Arnold

The pressure of rising health care costs on state budgets, employer payrolls and American families has again brought health care cost control to the forefront of state regulatory agendas.

Tired of waiting for the federal response to the nation's health care ills, most states have begun to examine options for initiating reform. This has brought new scrutiny to state programs designed to contain costs, monitor quality and promote access to care. An increasing number of states are re-examining the effectiveness of their Certificate of Need programs and considering their role in the rapidly changing health care environment.

Certificate of Need (CON) is a regulatory review process that requires certain health care organizations, such as hospitals, nursing homes and physician groups, to obtain authorization from the state for major capital expenditures, the purchase of high technology equipment and the expansion of services.

The use of capital review programs at the state level began with voluntary state programs and accelerated with the passage of Section 1122 of the 1972 amendments to the Social Security Act, which stipulated that states must review all capital expenditures that exceeded $100,000, changed bed capacity or involved a "substantial change" in services. States not reviewing such expenditures were subject to a loss of Medicare capital reimbursement, federal Medicaid payments and payments through the Maternal and Child Health Program.

In 1974, the National Health Planning and Resources Act went further, requiring states to enact Certificate of Need to receive funds through the Public Health Service. While some states implemented CON to contain costs, improve access or monitor quality, others simply did so to conform with federal requirements.

Since the 1986 repeal of the National Health Planning and Resources Act, 12 states have repealed part or all of their CON or allowed it to sunset. Many of the states repealing CON substituted other regulation, especially for long-term care. The 38 remaining state programs vary widely with respect to the types of services reviewed, dollar thresholds for capital review, the quality of the State Health Plan stipulating program goals, the stringency with which regulations are enforced and in a variety of other ways.

This diversity provides the opportunity to compare a variety of approaches to capital review.

CON's Effectiveness In Acute Care

In the acute care sector, CON typically requires hospitals to file for review when expanding bed capacity or adding clinical services. State regulators thought that by controlling excess hospital capacity and limiting services, CON would moderate increases in health care costs, maintain access to care and promote quality. While CON programs have not met all of these expectations, they have achieved some modest successes that are often overlooked.

> Certificate of Need programs have not been successful in holding down hospital costs.

Acute Care Costs

CON programs have not been successful in holding down hospital costs. This conclusion is based on extensive empirical analyses of hospital costs between 1980 and 1989. Our findings concur with a number of studies conducted during the 1970s, concluding that the program did not decrease hospital costs during that time (Sloan, Steinwald 1980) (Policy Analysis, Inc., 1981), and two more recent studies that showed CON associated with modest increases in costs in the early 1980s. (Ashby 1984 and Federal Trade Commission 1988) These national results may not hold for a given state, since each program is unique. They do, however, hold in Ohio and Pennsylvania, two states analyzed in detail. (Lewin-VHI 1991 and Lewin-VHI 1992a)

Legislators also are frequently interested in whether costs increased in states that repealed CON. We have found no evidence of increased costs in the 12 states that repealed their CON programs. There was expansion of certain services in these states, as will be discussed in the following section. However, these results cannot be used to predict the potential consequences of repeal in other states since the regulatory, market and other circumstances in each state are unique.

What has hindered CON programs from successfully controlling acute care costs? There are four primary factors. First, CON targets only a small portion of a hospital's overall budget. Control of capital spending has no effect on cost increases caused by the rise in labor, hospital-specific inflation and innovative uses of surgical techniques.

Second, the program does nothing to affect the prices that a hospital can charge. Third, the health policy literature shows that reductions in hospital bed capacity (a major target of CON programs) do not usually reduce the use of services. (Friedman, Pauly 1983 and Schwartz, Joskow 1980) In fact, closing inexpensive community hospitals can actually add to costs, as patients go to more sophisticated and expensive sites for care. (Pauly, Wil-

Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?

Christopher J. Conover and Frank A. Sloan
Duke University

Abstract This study assesses the impact of certificate-of-need (CON) regulation for hospitals on various measures of health spending per capita, hospital supply, diffusion of technology, and hospital industry organization. Using a time series cross-sectional methodology, we estimate the net impact of CON policies on costs, supply, technology diffusion, and industry organization, controlling for area characteristics, the presence of other forms of regulation, such as hospital rate-setting, and competition. Mature CON programs are associated with a modest (5 percent) long-term reduction in acute care spending per capita, but not with a significant reduction in total per capita spending. There is no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations. Mature CON programs also result in a slight (2 percent) reduction in bed supply but higher costs per day and per admission, along with higher hospital profits. CON regulations generally have no detectable effect on diffusion of various hospital-based technologies. It is doubtful that CON regulations have had much effect on quality of care, positive or negative. Such regulations may have improved access, but there is little empirical evidence to document this.

For more than two decades, health care cost containment has been at the forefront of the health policy agenda. However, the approaches used to achieve cost containment have changed. One of the first policies adopted by states (and that for a time was required by federal statute) was certificate-of-need laws (CON). Such laws, which focused on hospitals and nursing homes, were adopted to curb needless duplication of ser-

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vices and consequent excess capacity. At the time, retrospective reimbursement provided guaranteed reimbursement even if facilities operated at well below capacity. Also, given nearly complete insurance coverage for hospitals, competition for patients occurred on a nonprice basis (Robinson and Luft 1987; Dranove, Shanley, and Simon 1992). The hospitals that could offer the most sophisticated range of services and equipment were most attractive to patients and their physicians. The price of such care did not matter, or at least it mattered much less. Competition by service expansion and proliferation of new technology has been termed the "medical arms race." At least in principle, CON regulations could control the medical arms race by requiring that organizations demonstrate need for a facility, service, or equipment before investing in them. Also, in the 1980s, some states expanded CON regulations to control the proliferation of ambulatory care providers that was occurring (Finkler 1985). Other perhaps secondary objectives of CON regulations were to promote access and to promote quality. A less charitable view is that CON regulations sought to establish entry barriers to protect the income of existing providers, especially hospitals (Feldstein 1988; Wendling and Werner 1980).

Several developments have occurred since the late 1960s and early 1970s that have lessened the popularity of CON regulations, especially as they affect hospital care. First, other regulatory mechanisms thought to be more effective in cost containment have been adopted. Primary among these is Medicare's Prospective Payment System (PPS), but some states implemented various forms of regulation of hospital rates and revenue. Although PPS is still in effect, hospital rate-setting remains in only one state.[1] Second, there has been substantial growth in various forms of managed care, stimulated in part by legislation, such as selective contracting laws. Although specific incentives differ, managed care provides incentives for hospitals to be concerned about cost. In this context, there is a perception that CON regulations may not be needed as much as they were previously to control hospital cost growth. As a result of managed care plan growth as well as implementation of PPS, demand for inpatient hospital care has decreased appreciably. Third, as discussed later, a substantial amount of empirical evidence accumulated by the early 1980s indicating that CON regulations were ineffective in cost containment. Research findings per se did not contribute to the demise of CON laws, but such findings probably coincided with

1. At various times, six different states had adopted this approach, with New York being the most recent to abandon it (on 30 June 1996).

experience-based impressions of policy makers and experts in the field. Fourth, the federal law requiring states to have CON regulations expired in 1986. Since then, fifteen states have dropped CON regulations for hospital services; about half of these have retained CON regulations for nursing homes.

Policy makers in many other states have been reluctant to drop CON laws because of a concern that removing them would lead to a surge in health care spending, including both capital expenditures (initially, subsequent to removal of CON laws) followed by increased operating expenses. Some largely anecdotal accounts of surges following removal of CON laws were reported (Simpson 1986; Lewin-ICF 1992b). Although PPS and managed care have changed incentives, these forces may be insufficient to offset the other inflationary factors that preceded these more recent developments. Second, there is concern that without restraint by CON regulations, market forces will exacerbate an existing maldistribution of facilities, thus placing a greater burden on the disadvantaged. Some observers are also worried that for-profit providers would benefit disproportionately from removal of CON regulations. Some view this as troublesome since for-profit facilities may be less willing to provide uncompensated care. Some studies have shown this to be so (see references in Kuttner 1996), but other studies indicate that the contribution to uncompensated or indigent care is about equal, whether measured in terms of the self-pay share of patients, the bad debt–charity care share of charges, or the share of revenue accounted for by Medicaid (see Sloan's 1988 review). Proliferation of low-volume facilities also is a concern on the grounds that high volume is associated with higher quality of care, at least for some procedures (Luft et al. 1990).

Absent from these policy discussions to date has been systematic empirical evidence of the experiences in states that have lifted CON regulations. Did a surge in spending occur? If so, for which types of facilities and services did the surge occur? Did removal of CON regulations open the doors to the for-profits? Conversely, did removal of CON regulations have beneficial effects, such as increasing price competition through promoting growth of managed care, which may have been restrained previously because of CON entry barriers? Compared with other approaches to cost containment, how well do CON regulations perform? This is an old question, but the track record for comparing alternative approaches to cost containment is now far longer than when most studies were conducted during the 1970s and 1980s. Furthermore, it is now possible to follow the experience of states that dropped CON instead of simply com-

paring states with CON to those that had not yet adopted it. Finally, for the first time, a fourteen-year, continuous time series of state per capita health spending data has become available from the U.S. Health Care Financing Administration (HCFA).[2]

This article provides new empirical evidence about these issues with regard to acute care services. In focusing on acute care services, we exclude nursing homes, hospices, and home health care, but we do include ambulatory surgery and visits to physicians' offices as well as to hospitals. Using a state time series of cross-sections, we assess the effects of lifting CON through 1993. The success of CON in cost containment is compared with other approaches. We show that mature CON programs are associated with a modest (5 percent) long-term reduction in acute care spending per capita, but with no significant reduction in total per capita spending. We also found no evidence of a surge in acquisition of facilities or in costs following removal of CON.

Our empirical specification is followed by a discussion of findings on CON, other regulatory programs, competition, control variables on expenditures on acute care services, hospital beds, service intensity, and profitability, diffusion of technology, and industry organization. We then evaluate our results, compare our findings with those from previous studies, and discuss previous research on effects of CON on quality and access. Although we do not present any new direct evidence about quality and access, these issues are clearly germane to states' decisions about whether CON should be retained.

Empirical Specification

Dependent Variables

We specified equations for the following dependent variables. To measure the effects of CON and other factors on per capita health spending, we defined dependent variables for (1) total expenditures on personal health care services; (2) total acute care expenditures (defined as total spending minus nursing and home health expenditures); (3) expenditures on hospital care; and (4) expenditures on physicians' services per person

2. These data have not been published, but can be obtained by sending a blank diskette to Anna Long in the Health Care Financing Administration's Office of National Health Statistics, Office of the Actuary, Room N3-02-02, 7500 Security Boulevard, Baltimore, MD 21244-1805.

for a state's resident population. We also obtained estimates of Medicare spending per elderly enrollee, including total Medicare expenses and Part A and Part B expenditures.[3] Unpublished estimates of personal health care expenditures by state and year in total and by component were obtained from HCFA for 1980–1993.[4] We also analyzed Medicare expenditures for 1980–1993. All monetarily expressed variables were deflated by the all-items Consumer Price Index.

Dependent variables for hospital supply were beds per 1,000 state residents; for service intensity, the dependent variables were expense per adjusted (for outpatient volume) patient day and per adjusted admission; the dependent variable for hospital profits was the ratio of total revenue to total expense. The revenue measure was for funds actually received by hospitals during the fiscal year, not for hospital charges. Data for these dependent variables for 1976–1993 came from the American Hospital Association's *Hospital Statistics* (AHA 1977–1994).

To measure the influence of CON and other factors on the variable diffusion of technology, we defined dependent variables for (1) the number of hospitals with open-heart surgery units (1980–1993), (2) for hospitals with organ transplant units (1980–1993), (3) for hospitals with ambulatory surgery units (1983–1993), and (4) for all ambulatory surgery units, including freestanding facilities, per one million state residents (1983–1993). The different time periods we studied were dictated

3. Our figure for total Medicare per elderly enrollee equals the sum of the per enrollee estimates for Part A and Part B. Given that not all Part A eligibles receive Part B, our figure is slightly different from the HCFA-reported state level estimates of total spending per enrollee who was eligible for either Part A or Part B during the year. This latter figure will fluctuate based on changes in the mix of Part A and Part B eligibles, so we sought a slightly more stable measure that can be interpreted as estimated spending for an elderly enrollee who had enrolled in both Part A and Part B.

4. Most readers may be aware that these HCFA estimates measure spending by place of service, so our measure of spending per state resident is not intended to be an accurate measure of resource consumption by residents in that state, given that many residents may cross state borders to seek care. HCFA is still working on the development of residence-adjusted per capita spending figures. However, even if these were available, we believe they would not have been appropriate for our analysis insofar as the impact of a state's CON should be reflected in all spending within its own borders, not just that of its own citizens. Given that our method in essence measures the influence of various factors on year-to-year changes in per capita spending, the measure we have chosen would be unsuitable only if there were large year-to-year variations in the extent of border-crossing, which seems improbable. On the other hand, we also recognize that if CON regulations had the effect of driving citizens to neighboring states to seek care, our analysis of HCFA data would not be able to detect it. Part of our motivation in also analyzing Medicare spending per eligible person—which is a residence-adjusted measure of spending—was to see whether we got consistent results using both place-of-service and place-of-residence measures of per capita spending.

by data availability.[5] Information on the first three variables came from the *Hospital Statistics* (AHA 1977–1994). Data for the fourth came from the SMG Marketing Group (1984–1995). For the variable industry organization, we defined dependent variables for the for-profit share of hospital beds[6] for 1976–1993 based on *Hospital Statistics* and the HMO enrollments as a fraction of the state population, information taken from the Group Health Association of America's *National Directory of HMOs* (GHAA 1977–1994). We used data for 1976–1993 in our analysis of HMO market share.

Examining Certificate-of-Need Laws

Four binary variables represented certificate-of-need laws: pre-CON—the year before and the first year CON was implemented; young CON—the first two years postimplementation; mature CON—the remaining years CON was in effect; and CON lifted—the first three years after the CON law was dropped. Pre-CON was included to capture anticipatory effects of CON. There is some empirical evidence that hospitals began some capital projects in anticipation of CON (Sloan and Steinwald 1980a). Once enacted, CON laws plausibly had greater effects after they had been in place for a number of years. The variable CON lifted was included to determine whether there was a surge in hospital investment (and consequently in hospital costliness) immediately after CON laws were dropped.

If CON laws constrain hospital investment and cost, the savings may be offset by greater expenditures in other parts of the health care sector, as others have argued (see e.g., Finkler 1987). By including analysis of the ambulatory sector and of total health care expenditures, we were able to examine this possibility.

Program age is only one aspect of CON programs that is heterogeneous. Programs also logically differ in *stringency*, which reflects the scope of coverage and the difficulty applicants have in securing certificates of need. In an alternative specification, we used a CON stringency

5. Because our observational unit was the state, our diffusion measures were based on counts of the number of facilities offering a particular service. At a lower level of aggregation, it would be useful to study whether additional units opened where existing units were, or where the facility was the first of its kind in the area.

6. We recognize that our results might have been somewhat different if we had measured the for-profit share as a percentage of revenues or admissions. Our convention here is typical of previous analyses of CON regulations using state or regional data (see Noether 1988; Lanning, Morrisey, and Ohsfeldt 1991).

measure originally developed by Lewin-ICF (1992a).[7] These measures took account of dollar thresholds used to determine whether a project was subject to CON review, in terms of the scope of specific categories of services subject to review. This produced a continuous numerical score that Lewin-ICF used to categorize states into three mutually exclusive categories: 1 = limited; 2 = moderate; 3 = stringent. These categorical scores were used in our analysis.[8]

Finally, for most of the observational period, states could adopt section 1122 programs at their option. Unlike CON, section 1122 allowed hospitals to make unapproved investments in plant, equipment, and services, but unless approved, there was no Medicare or Medicaid reimbursement for the capital expenditures associated with the projects. The section 1122 variable measured the fraction of hospital revenues from Medicare and Medicaid by state and year, only for the years that section 1122 was in effect in a given state.

Hospital Rate-Setting

An explanatory variable for Medicare Prospective Payment measured the fraction of hospital revenues covered by PPS by state and year. The variable accounts for the years the program was phased in (1984–1987) as well as the fraction of hospital revenue from Medicare by state and year. We also measured the fraction of hospital revenue covered by mandatory rate-setting programs.[9] Following previous work by one of the authors (Sloan 1981), we distinguished between young rate-setting —the first three years of implementation—and mature rate-setting, the remaining years that CON laws were in effect. The variables were defined to reflect the fraction of revenue covered by the program.

7. More recent data for this measure are reported in Lewin-VHI (1995).

8. The Lewin-ICF methodology was not explained in enough detail to replicate the continuous scoring system. Because we had to interpolate figures for 1991 (based on reported figures for 1990 and 1992) and extrapolate to 1993 based on other available information about changes in thresholds, we were able to do so more reliably with the categorical data (whose values tended to be stable over time for any given state) than if we had attempted to replicate the continuous scoring system.

9. Previous work by Sloan (1981) examined a wider range of hospital rate-setting programs, including voluntary and advisory programs. Both theory and most evidence suggest that mandatory prospective rate-setting is the most effective form of hospital rate regulation (Biles, Shramm, and Atkinson 1980; Morrisey, Sloan, and Mitchell 1983; Sloan 1983; Rosko 1989).

Reimbursement

Explanatory variables were included to represent the fractions of hospital revenue that came from Medicare and from Medicaid programs, respectively.

Price Competition

The HMO share—calculated by dividing HMO enrollment by resident population on 1 July of each year—was used to represent the influence of managed care on hospital costs.[10] These data were obtained from GHAA's *National Directory of HMOs*.

Area Characteristics

We controlled for other factors likely to affect the dependent variables: income per capita population (Bureau of Economic Analysis estimates); the ratio of general practitioners to all physicians; the fraction of population over age sixty-five (Bureau of the Census); the population density (Bureau of the Census); and the weekly wage paid to service workers (Bureau of Labor Statistics [BLS] 1976–1994).

Other Explanatory Variables

To capture omitted cross-sectional and intertemporal influences, we included state binary variables and a time trend. To conserve space, coefficients and standard errors on the intercept, state binary variables, and the Voluntary Effort (only included in analysis that spanned the 1970s but not presented because it is no longer of policy interest) are not presented in the tables shown here.[11] To allow us to distinguish between short- and long-run influences on explanatory variables, we included

10. Unfortunately, analogous data on PPO enrollments were not sufficiently reliable to use in our analysis because of changes in definitions over time. HMO share is not a perfect measure of price competition insofar as it does not take into account the nature of plans offered (e.g., group model versus independent practice association) or the aggressiveness of purchasers in the market, which strongly influences the degree to which HMO presence actually affects competition and hospital costs (Robinson 1995; Zwanziger and Melnick 1996). Despite its limitations, HMO share has been shown to be related to price (premium) levels in two different studies (Wholey, Feldman, and Christianson 1995; Feldstein and Wickizer 1995), so in the absence of a better measure, we feel justified in using it.

11. The Voluntary Effort was a voluntary cost-containment effort promoted by the American Hospital Association to diminish support for President Carter's proposed price controls on hospitals. This effort began in December 1977 and lasted until about 1980 (Sloan 1983).

lagged dependent variables. The coefficient on the dependent variable is interpretable as one minus the fraction of the gap between the actual and the equilibrium value of the dependent variable that is closed in a year (λ). Thus, if the coefficient were .8, .2 of the gap would be closed annually. To obtain the long-run influence, the coefficient on an explanatory variable is divided by λ.

Functional Form

With the exception of the HMO share equation, all dependent variables were expressed in natural logarithm form, as were the variables in the other explanatory variables category; all other explanatory variables were entered linearly. Since there were an appreciable number of observations with no HMOs (about one hundred), we estimated the HMO share equation in linear form.

Results

Effects of Certificate-of-Need Laws

Certificate-of-need laws had no effect on total personal health expenditures per capita or on per capita spending on physicians' services (Table 1). For spending on acute care, mature CON had a negative impact that was statistically significant at the five percent level. The long-run effect of mature CON was an almost five-percent reduction in per capita acute care expenditures, which includes ambulatory care as well as hospital expenditures. However, we were unable to detect a statistically significant effect of removing CON on these same expenditures. Surprisingly, in view of this finding, mature CON did not have a statistically significant effect in reducing hospital spending, and in this regression, the coefficient on the variable CON lifted has a negative sign (statistically significant at the 10 percent level).

For Medicare expenditures, the only statistically significant CON coefficients have positive signs. A positive sign on CON lifted suggests a surge in Part A (i.e., hospital expenses), but the positive sign on mature CON in the Part B regression suggests that physicians' services may have substituted for hospital care when the latter was constrained.

On the whole, the section 1122 program seems to have been effective in containing costs. Negative and statistically significant coefficients were obtained in most regressions, but strangely, not in the regression

Table 1 Expenditures on Acute Care Services

	Medical Spending/Pop. (HCFA)				Spending Per Medicare Eligible Age 65+		
	Total Spending	Acute Spending	Hospital Spending	Physician Spending	Total Medicare	Part A	Part B
CERTIFICATE-OF-NEED REGULATION							
Section 1122	–.012[b]	–.018[b]	–.001	–.029[c]	–.049[c]	–.090[b]	.053
	(.005)	(.007)	(.010)	(.015)	(.029)	(.045)	(.063)
Young CON	.006	.001	.0002	–.0001	.002	–.013	.041
	(.006)	(.007)	(.010)	(.015)	(.029)	(.045)	(.064)
Mature CON	–.004	–.009[b]	–.005	.004	.029[c]	–.008	.163[a]
	(.003)	(.004)	(.006)	(.009)	(.017)	(.027)	(.038)
CON Lifted	–.004	–.006[c]	–.010[c]	.003	.032[c]	.017	.143[a]
	(.003)	(.004)	(.006)	(.009)	(.017)	(.026)	(.038)
HOSPITAL RATE-SETTING							
Prospective Payment System (PPS)	.042[a]	.018	.091[a]	.103[b]	–.254[a]	–.401[a]	.169
	(.016)	(.022)	(.031)	(.045)	(.083)	(.128)	(.182)
Young Mandatory Prospective	–.038[b]	–.036[c]	–.063[b]	–.065[c]	.051	–.024	.253
	(.015)	(.021)	(.029)	(.043)	(.082)	(.126)	(.178)
Old Mandatory Prospective	–.011[c]	–.017[c]	–.022[c]	–.027[c]	–.073[b]	–.101[c]	–.052
	(.006)	(.009)	(.012)	(.018)	(.034)	(.053)	(.075)
REIMBURSEMENT							
Medicaid Share	.059[a]	.082[a]	.153[a]	–.039	.125	.330[c]	–.322
	(.022)	(.030)	(.042)	(.063)	(.120)	(.185)	(.261)
Medicare Share	–.179[a]	–.204[a]	–.330[a]	–.092[b]	.008	.124	–.246
	(.017)	(.023)	(.033)	(.047)	(.089)	(.139)	(.193)
COMPETITION							
HMO Market Shares	.033	.011	.041	.031	–.178	–.330[c]	–.420
	(.025)	(.034)	(.049)	(.072)	(.137)	(.208)	(.295)

Table 1 Continued

	Medical Spending/Pop. (HCFA)				Spending Per Medicare Eligible Age 65+		
	Total Spending	Acute Spending	Hospital Spending	Physician Spending	Total Medicare	Part A	Part B
AREA CHARACTERISTICS							
Income Per Capita	.006	−.002	.011	.071[b]	−.249[a]	−.168[c]	−.513[a]
	(.012)	(.016)	(.023)	(.034)	(.065)	(.099)	(.141)
General Practitioner	.061[a]	.089[a]	.088[a]	.019	.442[a]	.521[a]	.599[a]
	(.016)	(.021)	(.030)	(.044)	(.084)	(.129)	(.183)
All Physicians	−.008	-.001	.069[c]	.135[b]	.412[a]	.334[c]	1.081[a]
	(.026)	(.033)	(.046)	(.067)	(.128)	(.197)	(.272)
Elderly	.065[a]	.100[a]	.051	.054	−.085	−.163	.207
	(.021)	(.028)	(.039)	(.059)	(.112)	(.172)	(.243)
Density	−.087[a]	−.127[a]	−.079[a]	.003	−.087	−.112	−.171
	(.016)	(.021)	(.030)	(.045)	(.085)	(.131)	(.186)
Service Wage	.046[a]	.045[b]	−.122[a]	.218[a]	.101[c]	.230[b]	−.053
	(.013)	(.018)	(.025)	(.038)	(.070)	(.108)	(.152)
OTHER							
Lagged Dependent	.847[a]	.815[a]	.732[a]	.508[a]	.458[a]	.358[a]	.105[b]
	(.022)	(.026)	(.030)	(.036)	(.034)	(.044)	(.042)
Time	.008[a]	.012[a]	.016[a]	.034[a]	.035[a]	.041[a]	.068[a]
	(.002)	(.002)	(.003)	(.003)	(.004)	(.006)	(.009)
R^2	.998	.997	.993	.989	.993	.985	.970
R^2(C)	.998	.997	.992	.988	.993	.983	.967
F	4547	2693	1136	770	1259	536	275
N	623	623	623	623	623	623	623

[a] Significant at the 1 percent level (two-tail test).
[b] Significant at the 5 percent level (two-tail test).
[c] Significant at the 10 percent level (two-tail test).

for total hospital spending. The largest negative effect was for Medicare Part A, which was directly affected by section 1122 controls.

Mature CON reduced bed supply by two percent (long-run effect). However, it raised hospital expense per adjusted patient day and per admission, and also increased hospital profitability (Table 2). Lifting CON had no impact on any of these dependent variables. Section 1122 lowered hospital profits, but the magnitude of this effect appears to be implausibly large.

Mature CON or its removal had no effect on diffusion of technology such as open-heart surgery units, organ transplant units, or ambulatory surgery units (Table 3). Availability of organ transplant units rose immediately after the implementation of CON, but this result could reflect the low number of such units in most states. Pre-CON was not included in any of the technology regressions, and young CON was not included in the regressions for ambulatory surgery, because there were no "young" programs during the observational periods for this analysis.

Both mature CON and CON lifted had positive influences on the for-profit share of the hospital market (Table 4). If a policy objective of retaining CON is to keep the for-profit market share in check, the empirical evidence, if anything, suggests that CON has the opposite effect.

Holding other factors constant, none of the CON variables affected HMO market share; however, the signs on the statistically insignificant coefficients are negative, suggesting that CON may have impeded HMO growth. Section 1122 had significantly positive effects on the for-profit share and a positive but insignificant effect on the HMO share.

In an alternative specification of CON, not shown, we examined whether our findings would persist once we had accounted for differences in stringency of CON across different states. The simplest way of measuring stringency is in terms of thresholds for coverage. States with high thresholds have less stringent programs insofar as fewer projects would qualify for review. We analyzed thresholds for capital and major medical equipment separately, and found very few instances in which these had an impact on the many measures examined. States with high capital thresholds (i.e., with less stringent CON) had lower Part B Medicare spending than did states with no CON.

When stringency was defined in terms of the Lewin-ICF categories described earlier, we found that states with limited CON had worse results than states with no CON. Limited CON states had higher hospital spending per capita and higher Medicare Part B spending per person over age sixty-five. For stringent CON, the effect on hospital spending

was not observed. However, in these states too, Part B spending was comparatively higl

Hospital Rate-Setting

Young state hospital rate-setting programs reduced the rate of growth in hospital expenditures overall, and thereby lowered growth rates in both acute care spending and total spending on personal health care services as well (Table 1). The magnitude of effects was lower for the mature programs. There were no statistically significant effects on expenditures for physicians' services. For Medicare, the mature programs had a stronger effect on hospital spending and on total spending. State rate-setting had no statistically significant effects on hospital bed supply, intensity, hospital profitability (Table 2), or on diffusion of technology with the exception of organ transplant units (Table 3).

Although PPS reduced Medicare expenditures through its effect on Part A expenditures, it seems to have had a positive effect on spending overall. These effects are not attributable to a secular trend in expenditures since we included a time trend as a separate explanatory variable. In contrast to state hospital rate-setting, PPS was negatively related to expense per adjusted admission, to expense per patient day, and to for-profit hospital market share, but was positively related to the HMO market share (Table 4).

Price Competition

Holding other factors constant, the HMO market share was associated with lower hospital bed supply, lower expense per adjusted admission, and lower diffusion of open-heart surgery units, but with greater diffusion of organ transplant units. For expenditures, only the effect of HMO share on Part A expenditures is negative and statistically significant at the 10 percent level or better. We split the sample between the periods 1988 and before and 1989 and after (results not presented). The negative effects of HMO share on Part A Medicare, on diffusion of open heart units, and on the number of hospital beds were statistically significant for the earlier but not for the later period. The HMO coefficient on profit was negative and statistically significant at the 10 percent level for the earlier period, but was insignificant for the latter.

Table 2 Hospital Beds, "Intensity," and Profitability

		Intensity		
	Beds per 1,000 Population	Expense per Adjusted Patient Day	Expense per Adjusted Admission	Hospital Profits
CERTIFICATE-OF-NEED REGULATION				
Section 1122	–.0004	–.007	–.002	–.272[b]
	(.008)	(.012)	(.009)	(.130)
Pre-CON	–.002	.007	.003	.263[a]
	(.006)	(.009)	(.007)	(.101)
Young CON	–.007	.006	.007	.256[a]
	(.006)	(.008)	(.006)	(.093)
Mature CON	–.008[c]	.011[c]	.010[b]	.153[b]
	(.004)	(.006)	(.005)	(.069)
CON Lifted	.002	–.001	.004	.018
	(.005)	(.008)	(.006)	(.085)
HOSPITAL RATE-SETTING				
Prospective Payment System (PPS)	–.095[a]	–.125[a]	–.105[a]	–.395
	(.025)	(.035)	(.027)	(.400)
Young Mandatory Prospective	–.005	.027	.038[c]	–.130
	(.018)	(.026)	(.020)	(.382)
Old Mandatory Prospective	.006	–.003	.005	.157
	(.010)	(.014)	(.011)	(.173)
REIMBURSEMENT				
Medicaid Share	.129[a]	.081[c]	.176[a]	–.689
	(.037)	(.053)	(.041)	(.613)
Medicare Share	–.003	.171[a]	.049[c]	2.020[a]
	(.023)	(.034)	(.026)	(.388)
COMPETITION				
HMO Market Shares	–.111[a]	–.003	–.186[a]	–.897[c]
	(.041)	(.054)	(.045)	(.604)
AREA CHARACTERISTICS				
Income Per Capita	–.044[b]	.021	.004	–.019
	(.018)	(.025)	(.019)	(.306)
General Practitioner	.042[b]	.032	.026	–.062
	(.017)	(.024)	(.019)	(.290)
All Physicians	.215[a]	–.002	.097[a]	–1.096[b]
	(.029)	(.044)	(.033)	(.469)
Elderly	.100[a]	–.019	–.070[b]	–.268
	(.026)	(.036)	(.028)	(.414)

Table 2 Continued

		Intensity		
	Beds per 1,000 Population	Expense per Adjusted Patient Day	Expense per Adjusted Admission	Hospital Profits
Density	−.024	−.005	.066[a]	−.125
	(.020)	(.029)	(.022)	(.312)
Service Wage	−.032[c]	.124[a]	.032[c]	1.175[a]
	(.020)	(.028)	(.022)	(.320)
OTHER				
Lagged Dependent	.616[a]	.803[a]	.801[a]	.318[a]
	(.021)	(.023)	(.021)	(.033)
Time	−.007[a]	.009[a]	.006[a]	.075[a]
	(.001)	(.002)	(.001)	(.017)
R^2	.986	.986	.990	.621
$R^2(C)$	.985	.984	.989	.586
F	818	802	1178	18
N	863	863	863	818

[a] Significant at the 1 percent level (two-tail test).
[b] Significant at the 5 percent level (two-tail test).
[c] Significant at the 10 percent level (two-tail test).

Discussion

The major findings about CON can be summarized as follows: first, we found no surge in expenditures after CON was lifted; second, despite a statistically significant reduction by mature programs on acute spending per capita, there was no corresponding reduction in total per capita spending (apparently due to offsetting expenditures on nonhospital services).

Empirical analysis of CON is an old topic. What is new or relatively new about our analysis is the research on the effects of lifting CON, the broad range of cost-related outcomes of CON studied, and the analysis of CON and other factors on a recently released data base of personal health care expenditures and their components. Particularly given the long history of empirical analysis of CON, it is important to review our evidence in the context of past research. A scorecard of previous studies of the effects of CON is shown in Table 5. Overall, the record for CON as a cost-containment mechanism appears to be mixed at best. If anything, our results provide slight optimism for CON's cost-containing potential relative to some other studies.

To date, only one other study has used the HCFA per capita spending

Table 3 Diffusion of Technology

	Open Heart Units/ Million	Organ Transplant Units/Million	Hospital-based Units/ Million	Total Units/ Million
CERTIFICATE-OF-NEED REGULATION				
Section 1122	–.069[c]	–.084	.001	.005
	(.046)	(.128)	(.022)	(.025)
Young CON	–.005	.235[c]	(—)	(—)
	(.046)	(.141)	(—)	(—)
Mature CON	–.009	–.071	.007	.012
	(.027)	(.078)	(.015)	(.017)
CON Lifted	.022	.019	.007	.021
	(.027)	(.074)	(.012)	(.013)
HOSPITAL RATE-SETTING				
Prospective Payment System (PPS)	.405[a]	–.278	.206[a]	.155[c]
	(.140)	(.407)	(.073)	(.081)
Young Mandatory Prospective	–.082	–1.427[a]	.009	.085
	(.128)	(.345)	(.095)	(.106)
Old Mandatory Prospective	–.031	.050	.022	.034
	(.054)	(.146)	(.028)	(.031)
REIMBURSEMENT				
Medicaid Share	.181	–1.22[b]	–.063	–.003
	(.190)	(.556)	(.102)	(.113)
Medicare Share	–.334[b]	.669	–.022	.023
	(.146)	(.418)	(.095)	(.105)
COMPETITION				
HMO Market Shares	–.495[b]	2.351[a]	–.050	.149
	(.228)	(.645)	(.118)	(.128)
AREA CHARACTERISTICS				
Income Per Capita	.044	.144	–.136[b]	–.113[c]
	(.101)	(.300)	(.056)	(.062)
General Practitioner	.339[b]	.071	.025	–.109
	(.133)	(.469)	(.078)	(.087)
All Physicians	.299[c]	.236	–.043	–.025
	(.197)	(.615)	(.099)	(.109)
Elderly	–.023	.416	.278[a]	–.001
	(.174)	(.560)	(.099)	(.108)
Density	–.117	–.253	–.216[a]	.066
	(.133)	(.416)	(.070)	(.076)
Service Wage	.060	–.755[b]	.041	.080
	(.113)	(.345)	(.059)	(.065)

Table 3 Continued

	Open Heart Units/ Million	Organ Transplant Units/Million	Hospital-based Units/ Million	Total Units/ Million
OTHER				
Lagged Dependent	.543[a]	.409[a]	.477[a]	.639[a]
	(.036)	(.039)	(.043)	(.038)
Time	.006	.036[b]	–.012[a]	.00001
	(.006)	(.017)	(.003)	(.003)
R^2	.931	.750	.988	.981
R^2(C)	.922	.716	.986	.979
F	112	22	532	337
N	617	541	479	479

[a] Significant at the 1 percent level (two-tail test).
[b] Significant at the 5 percent level (two-tail test).
[c] Significant at the 10 percent level (two-tail test).

data to assess the impact of CON. Examining data through 1982, Lanning, Morrisey, and Ohsfeldt (1991) found that after controlling for the fact that per capita spending was significantly different in states which adopted CON early, CON was associated with a 20.6 percent *increase* in hospital spending and a nine percent increase in spending on other health care. The net impact was a 13.6 percent increase in per capita spending on personal health care services. Using data derived from the annual *Hospital Statistics* on per capita hospital spending through 1990 (AHA 1977–1994) and a method that accounted for endogeneity of CON, Antel, Ohsfeldt, and Becker (1995) reported that CON had no impact on this form of spending, although they found that section 1122 reduced hospital spending. Without controlling for the endogeneity of CON, the coefficient on the CON variable was negative but very small, with a t-ratio of –.47. Taking account of endogeneity, the coefficient on CON became positive and statistically significant at the 10 percent level. It is noteworthy that explicitly accounting for CON's endogeneity made it appear to perform *less* well. Salkever and Bice (1976) found no impact of CON on total hospital operating costs per capita. Likewise, an earlier study by the Federal Trade Commission found that CON had no impact on hospital costs, but also found that section 1122 had a negative influence (Sherman 1988). By contrast, in our study, neither mature CON nor section 1122 had an impact on this type of expenditure, although both were associated with lower growth in acute care spending.

Table 4 Industry Organization

	For-Profit Share of Beds	HMO Market Share
CERTIFICATE-OF-NEED REGULATION		
Section 1122	.211[b]	.436
	(.101)	(.364)
Pre-CON	.121	–.279
	(.115)	(.312)
Young CON	.149	–.176
	(.108)	(.285)
Mature CON	.120[c]	–.155
	(.064)	(.213)
CON Lifted	.139[b]	–.335
	(.059)	(.234)
HOSPITAL RATE-SETTING		
Prospective Payment System (PPS)	–.800[b]	1.357
	(.364)	(1.154)
Young Mandatory Prospective	.369	.971
	(.578)	(.875)
Old Mandatory Prospective	–.195	.341
	(.157)	(.444)
REIMBURSEMENT		
Medicaid Share	.329	.938
	(.420)	(1.575)
Medicare Share	.513[c]	3.837[a]
	(.320)	(1.008)
COMPETITION		
HMO Market Shares	.255	(—)
	(.589)	(—)
AREA CHARACTERISTICS		
Income Per Capita	.289	.0001[c]
	(.243)	(.0001)
General Practitioner	.751[a]	–.075[a]
	(.263)	(.024)
All Physicians	.016	–1.247[a]
	(.370)	(.311)
Elderly	–.684[c]	.035[a]
	(.352)	(.053)
Density	.003	–.0002
	(.248)	(.0006)
Service Wage	–.700[b]	.012[a]
	(.294)	(.004)

Table 4 Continued

	For-Profit Share of Beds	HMO Market Share
OTHER		
Lagged Dependent	.585[a]	.879[a]
	(.039)	(.019)
Time	.016	.038
	(.013)	(.028)
R^2	.961	.976
R^2(C)	.955	.974
F	154	463
N	456	815

[a] Significant at the 1 percent level (two-tail test).
[b] Significant at the 5 percent level (two-tail test).
[c] Significant at the 10 percent level (two-tail test).

In our analysis, adoption of CON was certainly exogenous, but eliminating CON may have been endogenous; that is, it was more likely to have occurred in states where legislatures perceived that cost increases were under control without relying on CON. To ascertain whether this was so, we specified CON lifted and the lagged dependent variable as endogenous variables. Instrumental variables excluded from the main equations were the Blue Cross–Blue Shield market share; share of government hospital beds; population; and values of these variables lagged one year. CON lifted, specified as a endogenous variable, had either no effect or a more negative impact on cost than when the variable was assumed to be exogenous. If the above argument held, one would have expected CON lifted to have had a more positive effect on cost when CON lifted was specified to be endogenous.

Further, in analysis not presented, we used a method developed by Hatanaka (1974) to correct for autocorrelated error terms in a pooled time series cross-section. We found some autocorrelation, both negative and positive, but the correction had only minor effects on our results.

Two newer studies by Lewin-ICF (Lewin-ICF and Alpha Center 1991; Lewin-ICF 1992a) took account of differences in CON stringency and found that CON had a negative impact on hospital costs. This evidence conflicts with ours, since, after accounting for stringency, we did not find that CON had a greater cost-constraining influence. On balance, we believe our results merit more confidence since we controlled for many more influences other than CON.

We found that mature CON reduced hospital bed supply per capita

Table 5 Empirical Studies of the Impact of CON on Hospital Costs

	Number of Studies Showing:		
Major Impact	Decrease	No Effect	Increase
Health Spending			
Spending per capita	0	0	1
Hospital expenses per resident	0	3	2
Total hospital costs	2	1	0
Supply/Utilization			
Hospital capital expenditures	2	5	2
Hospital bed supply	2	3	1
Admissions per 1,000	0	2	0
Intensity			
Cost per patient day	2	1	2
Average length of stay	0	2	0
Cost per admission	0	2	6
Resource Mix			
Assets per bed	0	3	1
Labor use per bed	0	1	1
Market Structure			
For-profit share of beds	1	3	1
Public share of beds	1	0	0

population, but could detect no increase in bed supply following removal of CON. The magnitude of the reduction we detected was small—two percent from mature CON. Using an estimate from Ginsburg and Koretz (1983) that a 1 percent reduction in bed supply results in a .4 percent decline in admissions (the predicted reduction in admissions), the 2 percent reduction in supply translates into less than a 1 percent reduction in admissions. For this reason, it may not be surprising that we show only a minor (statistically insignificant) decline in hospital spending.

One of the earliest studies of CON found that CON reduced hospital bed supply, but also led to increased investment per bed (Salkever and Bice 1976, 1979). The result was no net saving on capital expenditures overall—simply a diversion of spending away from beds into other types of capital equipment that, due to less precise standards for judging need, was less well controlled. Sloan and Steinwald (1980b) also found a compensatory response to CON regulation, but it took the form of higher spending on labor rather than greater investment in other forms of capital. Since then, most studies have found that CON had no detectable impact

on hospital bed supply (Eastaugh 1982; Ashby 1984; Lewin-VHI 1995) or on hospital capital spending (PAI-US 1980; Eastaugh 1982; Begley, Schoeman, and Traxler 1982; Ashby 1984; Wedig, Hassan, and Sloan 1989). In fact, only two studies since the landmark study by Salkever and Bice (1976) found evidence that CON reduces bed supply (Joskow 1980; Begley, Schoeman, and Traxler 1982). Whether the true effect of CON is slightly negative or not, there are certainly better ways to control hospital bed supply, in particular by promoting HMO growth. The effect of HMO share on bed supply in our analysis was over ten times that of mature CON.

We found that mature CON increased cost per adjusted patient day and per admission. The mechanism is presumably that cost-increasing investments are unconstrained or, as Sloan and Steinwald found, there is a compensatory response in use of labor, and as a consequence there is an increase in operating costs. Many previous studies have reported results consistent with ours (Salkever and Bice 1979; Sloan and Steinwald 1980a; Sloan 1981; Farley and Kelly 1985; Noether 1988; Anderson et al. 1989; Lewin-ICF and Alpha Center 1991; and Antel, Ohsfeldt, and Becker 1995). Fewer have found no impact (Sloan 1983; Lewin-VHI 1995).

In this study, the now-defunct section 1122 program had no effect on either cost measure, a result consistent with Antel, Ohsfeldt, and Becker 1995; however, Noether (1988) reported that section 1122 reduced cost per admission by seven percent.

We reviewed eight previous studies that examined the impact of CON on diffusion of technology. In nearly seventy separate tests of the relationship between CON and the rate or extent of diffusion contained in these studies, only about one-third found that CON retards diffusion; a few, like our result for organ transplant units, found that CON accelerates diffusion, but the majority found no effect in either direction. None dealt with ambulatory surgery units; we found that CON had no effect on their diffusion.

Taken at face value, these studies suggest that CON appears to have slowed diffusion of the following technologies: hospital-based cardiac catheterization units, CAT-scan units, and MRI units (Lewin-ICF and Alpha Center 1991); open-heart surgery units (Russell 1979; Lewin-ICF and Alpha Center 1991); hip arthroplasty and morbid obesity surgery (Sloan et al. 1986); cobalt therapy (Russell 1979); and nonhospital-based renal dialysis (Ford and Kaserman 1993).

Yet, for the following reasons, even these favorable findings do not provide unambiguous support for the view that CON retards diffusion of expensive technologies. First, there are conflicting results. For example, although Lewin-ICF (1992a and Lewin-ICF and Alpha Center 1991)

found that CON reduced diffusion of MRIs, Teplensky et al. (1995) reported that more stringent CON policies caused an increase in diffusion of such units. Second, some results are counterintuitive. For example, Sloan et al. (1986) reported that CON had no impact on diffusion of coronary bypass graft surgery (CABG) units, a result consistent with the findings reported here. However, the same analysis showed that CON slowed diffusion of hip arthroplasty and morbid obesity surgery. The latter procedures were not subject to CON review, whereas CABG is subject to review in the vast majority of states with CON. Further, explicit guidelines for review had been developed by the agency responsible for federal oversight of state CON programs. No such guidelines existed for the other types of surgery.

There has been comparatively little research on the effect of CON on market structure. Concerns have been expressed that, absent CON, there will be a flood of for-profit entrants. However, the limited empirical evidence suggests no differential effect of CON on for-profit hospitals (Sloan and Steinwald 1980b). Using a time series of state cross-sections, Wedig, Hassan, and Sloan (1989) showed that the for-profit market share was unrelated to CON. In the current study, we found that mature CON stimulated growth of the for-profit hospital market share, and holding other factors constant, that the share was higher during the immediate period after CON was lifted. Rather than confirming the fears of those who favor retaining CON, our result for CON lifted could reflect a spillover from mature CON. This explanation seems especially likely, given the result for mature CON.

Our finding that CON had negative, albeit insignificant effects on HMO market penetration could reflect endogeneity, although this should have been handled by our fixed-effects analysis. That is, states with low HMO market shares may be reluctant to lift CON. We examined HMO market shares in the year that states lifted CON. They ranged from a high of 24.0 percent for California to lows of 1 percent or less for Idaho, New Mexico, South Dakota, and Wyoming. Preferred provider organization (PPO) penetration was also very low in these states (unpublished data from the American Medical Care and Review Association). Clearly, these states had something other than the presence of high HMO or PPO penetration in mind when they dropped CON. In many of the states that lifted CON, the HMO market share was below the national mean. In all of the states, there has been appreciable growth in managed care since they dropped CON.

Unlike research in many areas of health policy, research into CON

effects on acute care costs provides a rather clear answer. CON has not succeeded in cost containment. Other cost-containment programs appear to work better, but even they appear to have lost their effectiveness as they matured. Certainly, from the regression results presented here and from the descriptive evidence we analyzed but have not reported, there is no reason to fear an expenditure surge after CON laws were lifted. But might CON laws be retained for other reasons?

Might CON improve quality of care? It might do this in at least two ways—first, by assuring adequate patient volume and second, by denying entry to facilities that lack the capacity to deliver high-quality care. There is substantial evidence for one aspect of the former, but no "hard" information on the latter.

Luft et al. (1990) compiled an extensive review of the literature on the volume-outcome relationship that we supplemented with our own review of research published in the 1990s. More than one hundred studies have examined the relationship between hospital volume and outcomes, either mortality or complication rates (e.g., infection rates, rates of reoperation), excessive lengths of stay, or other indicators of patient health status. Although the underlying mechanism is not understood, most studies show higher rates of good outcomes in higher volume facilities. By contrast, there are far fewer studies of the relationship between physician volume and outcomes, and for reasons that are also not well understood, the link between volume and outcomes is less clear.

If the relationship between hospital volume and outcomes is accepted as valid, the question remains whether or not CON increases volume. Only one study has assessed the effect of CON on outcomes directly. Analyzing data from nearly 1,000 hospitals, Shortell and Hughes (1988) found that states with more stringent CON policies or more stringent hospital rate-setting experienced higher mortality rates. Although this analysis would suggest that lifting CON may result in favorable effects on mortality, such an inference would be having it both ways. Given that there appears to be no surge in costs following removal of CON, nor much if any effect of mature or stringent CON on hospital costs, nor much if any effect on diffusion of technology, why CON should have an *adverse* impact on mortality defies explanation.

Finally, there is the potential impact of CON on access. The 1974 National Health Planning and Resources Development Act, which mandated that states have CON, contained several provisions designed to promote better access to care. For example, consumer members were

required to outnumber provider members on local planning boards (Sloan 1988). Also, any Health Systems Agency plan that failed to address needs of low-income persons was subject to challenge at a public hearing.

There is a paucity of empirical studies of effects of CON on access to acute care services. One study conducted in Florida reported that a hospital's success in obtaining CON approval was consistently related to the amount of indigent care that it provided (Campbell and Fournier 1993). A study of California hospitals found evidence consistent with the hypothesis that hospital regulators reward large uncompensated care providers with profitable CON licenses, although no CON variables were actually used in estimating the amount of uncompensated care given by providers (Campbell and Ahern 1993).

Even though this information is suggestive, it is difficult to use it as a basis for continuing to support CON. First, it only applies to two states. Second, there must be more efficient ways to promote access than conferring monopoly franchises on facilities. Efforts to promote access are likely to be more productive if they are focused on primary care providers. Lack of adequate and timely primary care has been found to lead to a significant number of avoidable hospitalizations (Billings et al. 1993)

Earlier studies were more favorable than ours to other regulatory programs such as PPS and state hospital rate-setting relative to CON. It is not that CON has become more effective, but rather that the other programs became worse performers in terms of cost containment as the provider community became more familiar with them.

Conclusion

Our empirical analysis of effects of CON on costs revealed that, at best, CON has had a modest cost-containing influence on hospital and other acute care services. We found no evidence for a surge in acquisition of new facilities or in costs following removal of CON. States that lifted CON did not experience a rise in spending on hospital and physicians' services relative to those that retained it. The conclusion of lack of surge even holds for facilities such as ambulatory surgery units that have experienced substantial growth in recent years. It is doubtful that CON has had much of a positive or negative influence on quality of care. CON may have improved access, but the empirical evidence for this is quite meager.

References

American Hospital Association (AHA). 1977–1994. *Hospital Statistics* (annual). Chicago: AHA.

Anderson, Gerard F., Judith R. Lave, Catherine M. Russe, and Patricia Neumann. 1989. *Providing Hospital Services: The Changing Financial Environment*. Baltimore, MD: Johns Hopkins University Press.

Antel, John J., Robert L. Ohsfeldt, and Edmund R. Becker. 1995. State Regulation and Hospital Costs. *Review of Economics and Statistics* 77(3):416–422.

Ashby, John L. 1984. The Impact of Hospital Regulatory Programs on per Capita Costs, Utilization, and Capital Investment. *Inquiry* 21(1):45–59.

Begley, Charles E., Milton Schoeman, and Herbert Traxler. 1982 Factors That May Explain Interstate Differences in Certificate-of-Need Decisions. *Health Care Financing Review* 3(4):87–94.

Biles, Brian, Carl Shramm, and J. Graham Atkinson. 1980. Hospital Cost Inflation under State Rate-Setting Programs. *New England Journal of Medicine* 303(12): 664–668.

Billings, John, Lisa Zeitel, Joanne Lukomnik, Timothy S. Carey, Arthur E. Blank, and Laurie Newman. 1993. Impact of Socioeconomic Status on Hospital Use in New York City. *Health Affairs* 12(1):162–173.

Bureau of Labor Statistics (BLS). 1976–1994. *Employment and Earnings* (monthly). Washington, DC: Government Printing Office.

Campbell, Ellen S., and Melissa W. Ahern. 1993. Have Procompetitive Changes Altered Hospital Provision of Indigent Care? *Health Economics* 2(3):281–289.

Campbell, Ellen S., and Gary M. Fournier. 1993. Certificate-of-Need Deregulation and Indigent Hospital Care. *Journal of Health Politics, Policy and Law* 18(4):905–925.

Dranove, David, Mark Shanley, and Carol Simon. 1992. Is Hospital Competition Wasteful? *Rand Journal of Economics* 23(2):247–261.

Eastaugh, Steven R. 1982. The Effectiveness of Community-Based Hospital Planning: Some Recent Evidence. *Applied Economics* 14(5):475–490.

Farley, Dean E., and Joyce V. Kelly. 1985. *The Determinants of Hospitals' Financial Positions*. Rockville, MD: National Center for Health Services Research.

Feldstein, Paul J. 1988. *Health Care Economics*. 3d ed. New York: Wiley.

Feldstein, Paul J., and Thomas M. Wickizer. 1995. Analysis of Private Health Insurance Premium Growth Rates: 1982–1992. *Medical Care* 33(10):1035–1050.

Finkler, Merton D. 1985. Changes in Certificate-of-Need Laws: Read the Fine Print. In *Incentive versus Controls in Health Policy: Broadening the Debate*, ed. Jack A. Meyer. Washington, DC: American Enterprise Institute.

———. 1987. State Rate Setting Revisited. *Health Affairs* 6(4):82–89.

Ford, Jon M., and David L. Kaserman. 1993. Certificate-of-Need Regulation and Entry: Evidence from the Dialysis Industry. *Southern Economic Journal* 59(4): 783–791.

Ginsburg, Paul B., and Daniel M. Koretz. 1983. Bed Availability and Hospital Utilization: Estimates of the Roemer Effect. *Health Care Financial Review* 5(1):87–92.

Group Health Association of America (GHAA). 1977–1994. *National Directory of HMOS* (annual). Washington, DC: GHAA.

Hatanaka, Michio. 1974. An Efficient Estimator for the Dynamic Adjustment Model with Autocorrelated Errors. *Journal of Econometrics* 2(3):99–220.

Joskow, Paul L. 1980. The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital. *Bell Journal of Economics* 11(2):421–444.

Kuttner, Robert. 1996. Columbia/HCA and the Resurgence of the For-Profit Hospital Business. *New England Journal of Medicine* 335(5):362–367.

Lanning, Joyce A., Michael Morrisey, and Robert L. Ohsfeldt. 1991. Endogenous Hospital Regulation and Its Effects on Hospital and Nonhospital Expenditures. *Journal of Regulatory Economics* 3(2):137–154.

Lewin-ICF. 1992a. *Appendix 1: Econometric Analysis of CON in Pennsylvania*, by Judith Arnold and Daniel Mendelson. Washington, DC: Lewin-ICF.

Lewin-ICF. 1992b. *Evaluation of the Pennsylvania Certificate-of-Need Program*, by Judith Arnold and Daniel Mendelson. Washington, DC: Lewin-ICF.

Lewin-ICF and Alpha Center. 1991. *Evaluation of the Ohio Certificate-of-Need Program*. Washington, DC: Lewin-ICF.

Lewin-VHI, Inc. 1995. *Potential Cost Shifting under Proposed Funding Reductions for Medicare and Medicaid: Final Report Prepared for the National Leadership Coalition on Health Care*, by John F. Sheils and David J. Ricks. Washington, DC: Lewin-VHI.

Luft, Harold S., Deborah W. Garnick, David H. Mark, and Stephen J. McPhee. 1990. *Hospital Volume and Patient Outcomes: Assessing the Evidence*. Ann Arbor, MI: Health Administration.

Morrisey, Michael A., Frank A. Sloan, and Samuel A. Mitchell. 1983. State Rate Setting: An Analysis of Some Unresolved Issues. *Health Affairs* 2(2):36–47.

Noether, Monica. 1988. Competition among Hospitals. *Journal of Health Economics* 7(3):259–284.

Policy Analysis, Inc., and Urban Systems Research and Engineering, Inc. (PAI-US). 1980. *Evaluation of the Effects of Certificate-of-Need Programs*. Vol. 1, *Executive Summary*. Washington, DC: U.S. Department of Health and Human Services, Health Resources Administration, Bureau of Health Planning and Resources Development.

Robinson, James C. 1995. Health Care Purchasing and Market Changes in California. *Health Affairs* 14(4):118–130.

Robinson, James, and Harold Luft. 1987. Competition and the Cost of Hospital Care, 1972–1982. *Journal of the American Medical Association* 257(23):3241–3245.

Rosko, Michael D. 1989. A Comparison of Hospital Performance under the Partial-Payer Medicare PPS and State All-Payer Rate-Setting Systems. *Inquiry* 26(1): 48–61.

Russell, Louise B. 1979. Regulating the Diffusion of Hospital Technologies. *Law and Contemporary Problems* 43(1):26–42.

Salkever, David S., and Thomas W. Bice. 1976. The Impact of Certificate-of-Need Controls on Hospital Investment. *Milbank Quarterly* 54(2):185–214.

———. 1979. *Hospital Certificate-of-Need Controls: Impact on Investments, Costs, and Use.* Washington, DC: American Enterprise Institute for Public Policy Research.

Sherman, Daniel. 1988. *The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis.* Washington, DC: U.S. Federal Trade Commission, Bureau of Economics.

Shortell, Stephen M., and Edward F. X. Hughes. 1988. The Effects of Regulation, Competition, and Ownership on Mortality Rates among Hospital Inpatients. *New England Journal of Medicine* 318(17):1100–1107.

Simpson, James B. 1986. Full Circle: The Return of Certificate-of-Need Regulation of Health Facilities to State Control. *Indiana Law Review* 19(4):1025–1127.

Sloan, Frank A. 1981. Regulation and the Rising Cost of Hospital Care. *Review of Economics and Statistics* 63(4):479–487.

———. 1983. Rate Regulation as a Strategy for Hospital Cost Control: Evidence from the Last Decade. *Milbank Quarterly* 61(2):195–221.

———. 1988. Property Rights in the Hospital Industry. In *Health Care in America: The Political Economy of Hospitals*, ed. Harold E. Frech, III. San Francisco: Pacific Research Institute for Public Policy.

Sloan, Frank A., and Bruce Steinwald. 1980a. Effects of Regulation on Hospital Costs and Input Use. *Journal of Law and Economics* 23(1):81–109.

———. 1980b. *Insurance, Regulation, and Hospital Costs.* Lexington, MA: D. C. Heath.

Sloan, Frank A., Joseph Valvona, James M. Perrin, and Killard W. Adamache. 1986. Diffusion of Surgical Technology: An Exploratory Study. *Journal of Health Economics* 5(1):31–61.

SMG Marketing Group. 1984–1995. *Freestanding Outpatient Surgery Centers: Report and Directory* (annual). Chicago: SMG Marketing Group.

Teplensky, Jill D., Mark V. Pauly, John R. Kimberly, Alan L. Hillman, and J. Sanford Schwartz. 1995. Hospital Adoption of Medical Technology: An Empirical Test of Alternative Models. *Health Services Research* 30(3):437–465.

Wedig, Gerard, Mahmud Hassan, and Frank Sloan. 1989. Hospital Investment Decisions and the Cost of Capital. *Journal of Business* 62(4):517–536.

Wendling, Wayne, and Jack Werner. 1980. Nonprofit Firms and the Economic Theory of Regulation. *Quarterly Review of Economics and Business* 20(3):6–18.

Wholey, Douglas, Roger Feldman, and Jon B. Christianson. 1995. The Effect of Market Structure on HMO Premiums. *Journal of Health Economics* 14(1):81–105.

Zwanziger, Jack, and Glenn A. Melnick. 1996. Can Managed Care Plans Control Health Care Costs? *Health Affairs* 15(2):186–199.

CAROLYN A. WATTS, PH.D.
PROFESSOR
ECONOMICS AND HEALTH POLICY
19920 174th Avenue N.E.
Woodinville, Washington 98072

April 2, 2002

Members of the HESS Committee
Alaska State Legislature
Juneau, Alaska

I am writing in opposition to HB 407. I believe the elimination of Certificate of Need (CON) in smaller isolated communities such as Fairbanks would have significant long term consequences for Medicaid expenditures and ultimately for the availability of essential medical services for all members of these communities.

For the past 27 years, I have taught and done research in the area of health economics and health policy at the University of Washington in Seattle. In that time, I have participated in numerous studies of the organization of health care markets, and several studies aimed at evaluating the impact of CON specifically. I was part of the study team that analyzed proposals to alter Washington's CON for the state legislature. I am among the researchers working with the Center for Studying Health Systems Change in Washington, D.C. to track changes in the health care financing and delivery systems of 12 communities around the United States. I visited Fairbanks in the spring of 1999, where I gave a session on the economics of health care in rural communities to the board of Fairbanks Memorial Hospital. During that visit, and another in September of 2000 when I spoke before a meeting of the Alaska Hospital and Nursing Home Association, I had the opportunity to talk with many members of the Fairbanks health care community.

I come from a discipline with a strong belief in the benefits of competitive markets. However, my work over the last three decades has convinced me that health care is not like pizza. In the market for pizza, we want a good, cheap pepperoni and sausage, and we don't worry that some people can't afford even a slice of plain cheese. We make our own decisions and pay out of our own pockets. In small communities, if the one pizza place goes out of business, we're sorry, but we either bake our own or eat Chinese. Not so for health care. While we want our health care providers to operate

efficiently, we don't value low prices more than quality and availability. Our insurance companies pay for the heart surgery that our doctor tells us we need, and we *do* care that our neighbor can't pay for his chronic diabetes treatment. If the only hospital in town goes broke, doing our own surgery is not an option.

Certificate of Need is a central component of how communities – especially smaller communities like Fairbanks – assure that competition doesn't dismantle the delicate interdependent web of financing that is necessary to assure the survival of essential medical services. If all patients and all payers paid the full cost of treatment, we could ask hospitals to behave more like pizza parlors. But the reality is they don't, they can't, and the likelihood that they ever will is small. CON doesn't *prohibit* competition, it just provides a process through which communities can make decisions about when and what kind of competition will yield benefits that outweigh its costs. It allows communities to be responsible stewards of important community assets (their hospitals), which they – as in the case of Fairbanks Memorial Hospital – generated funds to build.

Some additional thoughts to consider:

- Repeal of CON in Ohio was followed by 13 closures of Level 1 obstetric and newborn services, leaving 2 counties without any services
- Since repeal, 152 ambulatory surgery facilities and 202 diagnostic imaging centers have been added in Ohio, and 16 hospitals have closed
- In Virginia, a legislative panel recommended delaying the loosening of CON controls because of the estimated $40 million cost of maintaining the financial viability of safety net hospitals that would be required in a competitive environment
- The analysis provided by Brian Rogers of Information Insights is much too simplistic to be useful. His calculations focus on the surgical services that would be provided by the surgery center, and he ignores the impact on other hospital services.
- Market entrants can promise to lower prices and offer charity care, but there is no mechanism to enforce their promises. Experience in other settings suggests that promises are often forgotten.
- While health care facilities provide the laboratories for medical professionals, physicians direct the care process. Ambulatory surgery and imaging services that are owned by physicians are not neutral competitors in the pizza market sense because their physician/owners can direct patients to their own facilities.

- Retaining CON controls on nursing homes and psychiatric hospitals will exacerbate the financial pressures on sole community hospitals if capacity in those areas is restricted and patients are placed in general inpatient beds as a (higher cost) substitute. Since Medicaid pays for a disproportionate share of nursing home and psychiatric services, this substitution will likely increase, rather than decrease, Medicaid expenditures.

In sum, 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 delivery systems that they have financed and that are an essential component of a community's infrastructure. I urge you to vote against HB 407, a bill that is likely to raise rather than lower Medicaid expenditures, and which may result in the unraveling of Alaska's health care system.

I would be pleased to respond to any questions, either by telephone or other means.

Sincerely,

Carolyn A. Watts, Ph.D.
Professor

September 2001 AUGMENTED CURRICULUM VITAE

CAROLYN (CINDY) WATTS

EDUCATION

University of Washington, Seattle, Washington
BA Economics, 1971

The Johns Hopkins University, Baltimore, Maryland
MA Political Economy, 1974

The Johns Hopkins University, Baltimore, Maryland
Ph.D. Political Economy, 1976

PROFESSIONAL POSITIONS

1969 Management Trainee, Credit Lyonnais, Rouen, France

1970 Management Trainee, Peoples National Bank, Seattle, Washington

1971 Management Trainee, S.A. Nicoll, Cholet, France

1969-1971 Grader/Research Assistant, University of Washington, Department of Economics, Seattle, Washington

1971-1972 Research Assistant/Consultant, Institute for Interdisciplinary Studies (Interstudy), Minneapolis, Minnesota

1973 Consultant, Policy Center, Inc., Washington, D.C.

1973 Health Services Industry Specialist, Cost of Living Council, Washington, D.C.

1974 Teaching Assistant, The Johns Hopkins University Department of Political Economy, Baltimore, Maryland

1973-1974 Research Associate, Policy Center, Inc., Denver, Colorado/Washington, D.C.

1975-1976 Acting Assistant Professor, Department of Economics, University of Washington, Seattle, Washington

1976-1980 Assistant Professor, University of Washington, Department of Economics

1978-1981 Assistant Professor, University of Washington, School of Public Health and Community Medicine, Department of
Health Services, Graduate Program in Health Services Administration and Planning

1981- Present	Adjunct Professor, University of Washington, Department of Economics
1983-1984	Visiting Associate Professor, Schools of Business and Public Health, University of California, Berkeley, California
1981-1984	Associate Professor, University of Washington, School of Public Health and Community Medicine, Department of Health Services, Graduate Program in Health Services Administration and Planning
1984-1994	Associate Professor, Faculty Director, Health Policy Analysis Program, Department of Health Services, University of Washington
1986- Present	Adjunct Professor, Graduate School of Public Affairs, University of Washington
1994- 1999	Professor, Faculty Director, Health Policy Analysis Program, Department of Health Services, University of Washington
1999- 2000	Professor, Acting Program Director Masters in Health Administration Programs University of Washington
2000- present	Professor, Associate Director Masters in Health Administration Programs University of Washington

HONORS

Freshman Women's Academic Honorary, 1967-1968

President's Letter of High Scholarship, 1968-1969

Alpha Omicron Delta, 1969-1970

Magna Cum Laude, 1971

Phi Beta Kappa, 1971

Graduate Fellowship, The Johns Hopkins University, 1972-1973, 1973-1974, 1974-1975

MEMBERSHIPS AND APPOINTMENTS

State Committees and Appointments

Technical Advisory Committee on Managed Health Care, Washington State Legislature, 1984-85

Working group on Six-Year Health Care Purchasing Plan, 1984-85

Washington State Hospital Commission Committee on UB-82, 1985

Technical Advisory Committee on Reimbursement Alternatives, Washington State Hospital Commission, 1982

Data Policy Committee, Washington State Hospital Commission, 1985-86

Chair, Technical Advisory Committee on Basic Research, Washington Health Project Commission, 1986

Task Force on State Health Policy, Senate Human Services and Corrections Committee, 1986

Supreme Court of the State of Washington, Novack Commission on Attorney Fees and Practice, 1987-1988

Washington State Medical Association, AIDS Task Force, 1987-89

Technical Advisory Committee, Rural Health Policy Commission, Washington State Legislature, 1988

Committee on Tax Reform, Seattle Economists Club, 1988

Advisory Committee, K-12 Study, Health Care Authority, 1990

Department of Health Tertiary Services Advisory Group, 1989-90

State Employee Benefits Board, 1989-1995

Task Force on Medical Savings Accounts, Washington Health Services Commission, 1994

National Committees and Appointments

Technical Advisory Committee on Hospital Classification, Health Care Financing Administration, 1978

Advisory Committee, State of Georgia Prudent Buyer Prospective Reimbursement System, 1974-1979

Advisory Committee on Case Mix Measurement Conference, American Hospital Association, October 1979

HCFA Grants Review Panel on Prospective Payment and Case Mix, 1984, 1985

Advisory Board to US Department of Labor study of working poor conducted by the Rand Corporation, 1988-1990

Governance Committee, Western Network Executive Health Administration Program, University of Colorado at Denver, 1988-1992

Chair, AUPHA Annual Meeting Management Research Committee, 1993

Proposal Reviewer, Robert Wood Johnson Investigator Awards Program, 1995

Editorial Board, Medical Care Research and Review, 1991-Present

Vice Chair, Program Committee, Sun Valley Forum, 1992-1994.

Member, Advisory Committee, Masters in Health Policy Program, Boise State University, 1996-present

Conference Chair, Risk Segmentation in the Health Care Market, Sponsored by the Robert Wood Johnson Foundation, New Orleans, February 1997

Member, National Advisory Committee, Mental Health Parity in the FEHBP, 2001

Member, National Advisory Committee, Risk Adjustment Impact Study, 2000-2001

Other

Veterans Administration, Seattle, 1984-1986
Health Services Research and Development Steering Committee

Puget Sound Health Systems Agency Ethics Committee Editorial Board, 1985-1986

Harborview Community Mental Health Center Committee on Legislative Affairs, 1985-1986

Small Grants Review Committee, Alcoholism and Drug Abuse Institute, University of Washington, 1986-1989

Prospective Payment System Planning Committee, University Hospitals, 1987-88

Hospitals Decision and Research Support System Committee, University of Washington Hospitals, 1987

Hogness Symposium Committee, 1989-91

Washington Health Advisory Committee 1989 - present

Dean's Representative to Governance Committee of the Human Services Policy Center, 1991-Present

Core faculty, Institute for Public Health Genetics, University of Washington, 1999-present

BIBLIOGRAPHY

PAPERS IN REFEREED JOURNALS

Hartman, R., and C.A. Watts. "The Determination of Average Length of Stay: An Economic Approach." Quarterly Review of Economics and Business, Autumn 1978.

Jackson, M., P. Diehr, J. LoGerfo, C.A. Watts, and W.C. Richardson. "Elective Hysterectomy: A Cost Benefit Analysis." Inquiry, 15:3, September 1978.
Watts, C.A., M. Jackson, and J. LoGerfo. "Cost Effectiveness Analysis: Some Problems of Implementation." Medical Care, 17:4, April 1979.

Watts, C.A., W.L. Dowling, and W.C. Richardson, "Strategies for the Reimbursement of Short-Term Hospitals." Annual Review of Public Health, 1:95-119, 1980.

Klastorin, T.D. and C.A. Watts. "On the Measurement of Case Mix for Hospitals Cost Containment." Medical Care, 18(6) :675-685, June 1980.

Conrad, D., and C.A. Watts. "A Note on Measuring the Extent of Competition in the Physician Services' Market: An Alternative Hypothesis." Research in Law and Economics, Vol. 3, 1981.

Watts, C.A., and T.D. Klastorin. "The Impact of Case Mix on Hospital Costs: A Comparative Analysis." Inquiry, 17:357-367, Winter 1980.

Klastorin, T.D. and C.A. Watts. "The Determination of Alternative Hospital Classifications." Health Services Research. 16(2):205-220.

Dolan, A., and C.A. Watts. "Adding Public Members to Governing Boards: A Critique." Journal of Contemporary Business. 9(4):87-95, 1980.

Klastorin, T.D., and C.A. Watts. "Costs in the Health Care Industry: An Overview." Journal of Contemporary Business. 9(4):1-8, 1980.

Klastorin, T.D., and C.A. Watts. "A Current Reappraisal of Berry's Hospital Typology." Medical Care. 20(5):441-449, May 1982.

Watts, C.A. "FTC Sings the Blues: A Comment." Journal of Health Politics. Policy and Law. 5(3):568-572, Fall 1980.

Watts, C.A., and T.D. Klastorin. "The Costs of Regulation: A Further Note." Health Services Research. 16(4):467-476, Winter 1981.

Wa[illegible], C.A. "Compensation of Hospital Based Physicians: A Comment." Health Services Research. 18(1):45-47, Spring 1983.

Watts, C.A., R.M. Scheffler, and N. Jewell. "Demand for Outpatient Mental Health Services in a Heavily Insured Population." Health Services Research. 21(2), Part II, June 1986.

Scheffler, R.M. and C.A. Watts. "Demand for Inpatient Mental Health Services in a Heavily Insured Population." Journal of Human Resources 21(3), 1986.

Crittenden, R.A., and C.W. Madden. "Health Insurance for the Uninsured: Plan Design Alternatives." Advances in Health Economics and Health Services Research. Winter 1988.

Conrad, D.A., S.S. Mick, C.W. Madden, G. Hoare, "Vertical Structures and Control in Health Care Markets: A Conceptual Framework and Empirical Review", Medical Care Review. 45:1 Spring 1988.

Madden, C.W. "Health Care Financing Issues for the Elderly." Health Matrix. 6(3): 26-29, Fall 1989.

Diehr, P., C. Madden, A. Cheadle, D. Patrick, P. Fishman, P. Char, and S. Skillman. "Estimating the Percent of People in a County Who Have No Health Insurance." 1991 (Winter) Inquiry 28:413-419.

Madden, C., G. Hoare, M. Mayers, and W. Hagens. 1992 (Spring). Washington's Basic Health Plan: Choices and Challenges. Journal of Public Health Policy 13(1):81-96.

Hoare, G., C.Madden, and M.Mayers. 1992 (Summer). Update: Lessons for the Implementation of Washington's Basic Health Plan. Health Affairs 11(2):212-218.

Patrick, D.L., C. Madden, P. Diehr, D.P. Martin, A. Cheadle, and S. Skillman. 1992 (October) Health Status and Use of Services Among Families With and Without Health Insurance. Medical Care 30(10):941-949.

Diehr, Paula, C.W. Madden, Diane Martin, Donald Patrick, 1993 "Who Enrolled in a State Program for the Uninsured?" Medical Care 31(12):1093-1105.

Madden, C.W. "Medicine, Public Policy, and Ecological Health," Illahee. Journal for Northwest Environment vol. 10, No. 2, Summer 1994 pp. 114-118.

Madden, C.W. et al, 1995 "Voluntary Public Health Insurance for Low Income Families. The Decision to Enroll. Journal of Health Politics, Policy and Law. 20(4):955-972.

Lichiello, P. and C.W. Madden, 1996. "Context and Catalysts for Change in Health Care Markets." Health Affairs. 15(2): 121-129.

Diehr,Paula, C. Madden, A. Cheadle, D. Martin, D. Patrick, S. Skillman, 1996. "Will Uninsured People Volunteer for Voluntary Health Insurance?" American Journal of Public Health. 86(4):529-532

Patrick, Donald, Diane Martin, Allen Cheadle, C.W. Madden, and Paula Diehr "Dissatisfaction and Disenrollment in a Subsidized Managed Care Program." 1997 Medical Care Research and Review.54(1):61-79

Martin, D.P., P. Diehr, A. Cheadle, C.W. Madden, D.L. Patrick, and S.M. Skillman. Health Care Utilization for the "Newly Insured": Results from the Washington Basic Health Plan," 1997. Inquiry. 34(2):129-142.

Kilbreath, E.H., A.F. Coburn, C. McGuire, D.P. Martin, P. Diehr, C.W. Madden, S.M Skillman. 1998. "State-Sponsored Programs for the Uninsured: Is There Adverse Selection?" Inquiry. 35(3):250-265.

Wilson, V. M., C. A. Smith, J. M. Hamilton, C. W. Madden, S. M. Skillman, B. MacKay, J. S. Mathisen, D. A. Frazzini. 1998. "Case Study: The Washington State Health Care Authority - Risk Adjustment for Capitation." Inquiry. 35(2): 178-192.

Madden, Carolyn. 1999. "Excess Capacity: Markets, Regulation and Values." Health Services Research. 33(6).

Blough, D. K., C. Madden, & M. Hornbrook. 1999. "Modeling Risk Using Generalized Linear Models." Journal of Health Economics. 18(2):153-172.

Madden, Carolyn W., Bret P. Mackay, Susan M. Skillman, Marcia Ciol, and Paula Diehr. 2000. "Risk Adjusting Capitation: Applications in Two Populations. Health Care Management Science. 3(2000):101-109.

PAPERS ACCEPTED FOR PUBLICATION

Austin, Melissa; D. Arnett; T. Beaty; S. Durfy; R. Fineman; E. Gettig; D. Lochner-Doyle; P. Peyser; J. Sorenson; J. Thompson; C. Watts. Forthcoming. "Opportunities for Public Health Genetics Trainees: An Employer/Workplace Survey." Community Genetics.

PAPERS SUBMITTED FOR PUBLICATION

Trude, Sally, J. Christianson, C. Lesser, C. Watts. "Employers' Responses to Rising Premiums: The Community Tracking Study." Submitted to Health Affairs.

PAPERS IN PROGRESS

Watts, Carolyn; J. Christianson; S. Trude. "Purchasing Decisions of Public Employers: The Community Health Tracking Study."

PAPERS IN NON-REFEREED JOURNALS

Jewell, N., A. Cheadle, R.M. Scheffler, and C.A. Watts. "Mental Health Use in an Insured Population: A Mixed Cohort Design." Proceedings of the American Statistical Association, August 1984.

Madden, C.W., "Universal Health Insurance: An End or a Means?" Frontiers of Health Management, Vol. 6, No. 4, Summer 1990.

Madden, C.W. "Washington's Basic Health Plan: Experimentation in a Turbulent Environment," Washington Public Health. 9(1): 42-43. Winter 1991.

Katz, Aaron, C.W. Madden, and Margo Westfall, "The 1993 Washington State Legislature: Dawn of a New Era," Washington Public Health. Vol 11, Fall 1993.

Madden, C.W. "Public Managed Care in Easterville: A Case of Opportunity," in Ambulatory Health Care Case Studies for the Health Services Executive. (A.Ross & M.Richardson, eds.) Health Information Press, 1995.

Watts, Carolyn. "The Economics Determinants of Health and Illness." Washington Public Health. Fall 2000.

ABSTRACTS

Diehr, P., C. Madden, D. Martin, and D. Patrick. Enrollment in a State Program for the Uninsured: Is there adverse selection? (presented at the American Public Health Association 119th Annual Meeting, November, 1991).

Martin, D., C. Madden, P. Diehr and D. Patrick. Evaluation of Washington State's Health Plan for the Uninsured (presented at the Annual Meeting of the Association of Health Services Research, June 1991).

Patrick, D., C. Madden, P. Diehr, D. Martin, A. Cheadle, and S. Skillman. Health Status and Use of Services Among Families With and Without Health Insurance (presented at the Annual Meeting of the American Sociological Association, August, 1991).

TECHNICAL REPORTS

O'Donoghue, D.P., and C.A. Watts. Estimated Costs for a Program Operated by a Health Care Quality Commission. Institute for Interdisciplinary Studies, June 1972.

Watts, C.A. Blood, Sweat and Tears, or the Continuing Saga of Consumerism. Institute for Interdisciplinary Studies, November 1972.

Watts, C.A. Coverage of Blood Banks Under Phase IV. Cost of Living Council, August 1973.

Watts, C.A. "National Health Insurance: The Crisis Revisited." Unpublished seminar paper, The Johns Hopkins University, May 1973.

Watts, C.A. "Physician Cooperation: Implications for Investment by Nonprofit Hospitals." Unpublished research paper, The Johns Hopkins University, April 1974.

O'Donoghue, D.P., C.A. Watts, et al. Synthesis of Current Evidence of the Effects of Health Care Regulation. Policy Center, Inc., National Science Foundation, Fall 1975.

Watts, C.A., G. Updegraff, H. Grayson, and A. Bryant. Health Care Cost and Price Regulations: Background Discussion and Annotated Bibliography. National Science Foundations, Fall 1975.

Watts, C.A., and G. Updegraff. Regulation of the Quantity of Institutional Facilities and Capital Equipment: Background Discussion and Annotated Bibliography. National Science Foundation, Fall 1975.

Watts, C.A., G. Updegraff, and P. Shaughnessy. Regulation of Other Industries in the United States: Selected Annotated Bibliography. National Science Foundation, Fall 1975.

Watts, C.A. "A Managerial Discretion Model for Hospitals." Doctoral Dissertation, the Johns Hopkins University, 1976.

Hartman, R. and C.A. Watts. The Determination of Average Length of Stay: An Economic Approach. Discussion of Paper #8, Center for Health Services Research, May 1978.

Klastorin, T.D., C.A. Watts, and V. Trivedi. A Study of Hospitals for Prospective Reimbursement. Research and Demonstration Series, Report No. 10, Health Care Financing Administration, Washington, D.C., 1978.

Klastorin, T.D., and C.A. Watts. "A Preliminary Analysis of Section 223 Regulations," Submitted to Health Care Financing Administration, July 1979.

Klastorin, T.D. and C.A. Watts. "The Impact of Case Mix Measures on Hospital Classification." Proceedings of the 2nd International Conference on System Science in Health Care, Montreal, July 14-17, 1980.

Watts, C.A. Antitrust in the Health Professions: Precedents and Projections. HMO Technical

Assistance Paper, University of Washington, March, 1983.

Watts, C.A. "Preliminary Report: Washington State Medical Association Study of Uncompensated Care," September 1985.

Watts, C.A. "Report on Certificate of Need." Office of the Governor, State of Washington, December 1985.

Watts, C.A. "The Effects of Changes in the Medical Liability Market on Washington Obstetricians." Washington State Medical Association, January 1986.

Watts, C.A., "A Report to the Legislature on Public Health in the State of Washington." Joint Select Committee on Public Health, January 1986.

Watts, C.A. "The Uninsured in Washington." Report of Technical Advisory Committee A to the Washington Health Project Commission of the Washington State Legislature, July 1986.

Watts, C.A. "Medicare Payment in State Veterans Homes: A Study of Feasibility." Submitted to the Washington State Department of Veterans Affairs, July 1986.

Madden, C.W. "The Prenatal Care Program in Washington State: A Four County Evaluation," Health Policy Analysis Program, April 1987.

Madden, C.W., "State Employee Insurance: Options", Health Policy Analysis Program, November 1987.

Madden, C.W. "The Environment Facing Rural Hospitals,"Health Policy Analysis Program, May 1988.

An Evaluation of the Sound Care Plan: Issues of Access, Quality, and Cost, with Aaron Katz and Michelle Bell, Health Policy Analysis Program, July 1989.

Madden, C.W., and Marcia Schwendiman, Health Policy Choices: A Background and Discussion, Final Report to Governor's Office, State of Washington, October 1988.

Economic Analysis of Proposed Water Quality Standards for Ground Waters of the State of Washington WAC 2000, with Institute for Public Policy and Management, May 1990.

An Evaluation of the Sound Care Plan, with Aaron Katz and Michelle Bell, Health Policy Analyses Program, July 1991.

Evaluation of the Community Alternatives Program, with Alice Porter, Paul Fishman, Aaron Katz, Health Policy Analysis Program, July 1992.

Evaluation of the Medical Selective Contracting Program, with Marcia Schwendiman, Fred Connell, Paul Fishman, and Aaron Katz, Health Policy Analyses Program, August 1992.

Madden, C.S., A. Katz. 1995. "Community Benefit, and Not for Profit Health Care: Policy Issues

and Perspectives. SPHCM, University of Washington

Madden, C.W., S.M. Skillman, P. Diehr, D.P. Martin, D.L. Patrick. Revolution and Reform: Lessons from Washington's experimental programs.

Madden, C.W., P. Diehr, D.P. Martin, A. Cheadle. 1994. Insurance status of Families in Washington State.

Cheadle, A., C.W. Madden, P. Diehr, D.L. Patrick, D.P. Martin and S.M. Skillman. 1994. Who Participates and Why in a Subsidized Insurance Plan?: Experience with Washington State's Basic Health Plan

Madden, C.W., S.M. Skillman, A. Cheadle, P. Diehr, D.P. Martin, D.L. Patrick. 1994. Health Insurance for the Low Income: An Evaluation. Final Report. Agency for Health Care Policy and Research, Grant #5-Ro1-HS060621. Seattle: University of Washington, Department of Health Services.

Madden, C.W., A. Katz. 1995. "Community Benefits and Not for Profit Health Care: Policy Issues and Perspectives." SPHCM, University of Washington.

Madden, C.W., M.T. Stanley, S.M. Skillman, D.K.Blough, B. MacKay, V. Wilson, S. Kilby, M.C. Hornbrook, M. Goodman, G.D. Bennett, L. Dey. 1995. "Risk Distribution Among Competing Health Plans Research and Demonstrations Project. Phase I Final Report." University of Washington: Seattle, WA.

Jansson, Roger, Carolyn Watts, Aaron Katz, Patricia Kuzler, Anna Mastroianni, Jack Thompson, and Andrew McWilliam. 2000. "Genetic Testing in the Workplace: Implications for Public Policy." Institute for Public Health Genetics, University of Washington.

Madden, Carolyn, Bret MacKay, and Susan Skillman. 2001. "Measuring Health Status for Risk Adjusting Capitation Payments in Two Medicaid Populations." Center for Health Care Strategies, Inc. Princeton, New Jersey.

BOOK REVIEWS

Williams, W., and C.A. Watts. "Equity in Health Services, Empirical Analysis in Social Policy: A Review." AUPHA Notes, May 1977.

Watts, C.A. "The Market for Human Blood." Inquiry, 16(2):180-181, Summer 1979.

Freund, D., and C.A. Watts. "Health Care Economics." Medical Care.

Watts, C.A. "A Quest for Certainty." AUPHA Program Notes.

Watts, C.A. "Issues in Health Care Economics." Hospital Forum

REVIEWS FOR JOURNALS

Medical Care
Inquiry
Health Services Research
Research in Law and Economics
National Science Foundation, Economics Division
American Hospital Association, Internal Proposal
National Center for Health Services Research
Medical Care Research and Review
Economic Inquiry
Veterans Administration
Alaska Science and Technology Foundation
American Behavioral Science Review

OTHER

Co-editor (with T.D. Klastorin) of special issue of Journal of Contemporary Business on health care costs.

Attended Emory University Law and Economics Center Legal Institute for Economists, Spring 1981.

PRESENTATIONS

"The Philosophy of Economics as Applied to Health Services Delivery." Presentation to the Western Institute of the Hospital Financial Management Association, Portland, Oregon, February 1976.

Roundtable on Health Economics, Clinical Scholars Program, May 1977.

"Hospital Classification: Conceptual Underpinnings." Seminar presented for the Office of Research, Health Care Financing Administration, Washington, D.C., June 1977.

Discussant, "Estimates of Occupational Injury Risk and Compensating Wage Differentials." Western Economic Association Conference, Los Angeles, June 1977.

"The Economics of Aging: Medical Care." Presentation and panel discussion, Washington State Public Health Association Conference, Ocean Shores, Washington, October 1977.

"The New Technology: Economic and Policy Issues." Tax/X Center for Health Planning Workshop, Seattle, Washington, October 1977.

"Hospital Classification for Prospective Reimbursement." Department of Health Services Seminar Series, University of Washington, January 1978.

"The Regulation of Hospital Reimbursement." Western Economics Association Meetings, Honolulu, June 1978.

"Grouping Hospitals for Prospective Reimbursement." California Health Facilities Commission, Sacramento, August 1978.

Panel Discussant, APHA Meeting, Los Angeles, October 1978.

"National Health Insurance." Womens' Health Care Professionals Meeting, May 1979.

"National Health Insurance: Issues and Problems." Regional Conference of Nurses, Fred Hutchinson Cancer Research Center, November 1979.

"If the Answer Isn't Regulation, What is it (Or Might it be)?" University of Washington, MHA Alumni Association Annual Meeting, April 1980.

"Health Economics." Group Health Cooperative of Puget Sound, January 1982.

"The Role of Antitrust in Health Economics." Western Network Health Care Executive Program, Berkeley, August 1983.

"Changes in Co-insurance and Deductibles and Demand for Psychiatric Service" with R. Scheffler et al., APHA meetings, Dallas, November 1983.

"Medicare Hospital Reimbursement: Impact of DRGs." Western Gerontological Society, San Francisco, November 1983.

"Demand for Outpatient Mental Health Services in a Heavily Insured Population." American Economic Association meeting, San Francisco, December 1983.

"Determinants of Inpatient Mental Health Use in a Heavily Insured Population." Conference on Mental Health Economics, NIMH, Berkeley, September 1984.

"The Impact of Financing on Health Services Delivery." Conference on Health Care Policy, Berkeley, August 1984.

"DRG-based Reimbursement: Concepts and Organizational Outcomes." Faculty Roundtable on Health Care Financing, Berkeley, February 1984.

"Demand for Mental Health Care in a Heavily Insured Population." Department of Health Services seminar series, October 1984.

"Managed Health Care in Washington State Health Policy." Seattle Chamber of Commerce, November 1984.

"The Changing Environment in Health Care Policy." Group Health Cooperative of Puget Sound continuing education program, 1985.

"Commercialism in Health Care: Are We Losing our Soul?" University of Washington MHA Alumni Day, May 1985.

"The Rural Hospital Project." Washington State Hospital Association Rural Hospital Annual Meeting, Chelan, Washington, June 1985.

"Current Issues in American Health Policy." Thirty-minute television program broadcast on Cablearn.

"Anti-trust in Health Care: The Case of Arizona vs. Maricopa County Medical Society." U.S. Department of Justice Anti-Trust Division, Washington D.C., August 1985.

"Changing Health Policy Environment: A Positive Response." Washington State Public Health Association Annual Meeting, September 1985.

"Health Policy and Economics." Seattle Association of Women Economists, September 1985.

"Certificate of Need: Background and Issues." Testimony before Human Services and Corrections Committee, Washington State Senate, September 1985.

"The Health Policy Analysis Program History and Issues." Departmental seminar, Fall 1985.

"Changing Payment Systems and Cost Shifting." Panel moderator, Innovations and Alliances '85 Conference sponsored by the Puget Sound Health Systems Agency, November 1985.

"Health Care Markets and Competition." Presentation to the Legislative Conference on Certificate of Need, November 1985. Sponsored by the Washington State Health Coordinating Council.

"Social Management of Risk." Department of Health Policy and Management, University of Massachusetts at Amherst, December 1985.

"Medicare Financing of State Veterans Homes." Testimony before Washington State Legislative Budget Committee, January 1986.

"Health Economics in a Changing Environment." Alumni Association, School of Business of the University of Colorado at Denver, February 1986.

"Economic Overview of the Health Care Industry." College of Medical Education, Medical Society of Pierce County, March 1986.

"Health Care in the '80s: A Forward Look." St. Joseph Health System strategic planning meeting, May 1986.

"The Uninsured in Washington." Testimony before the Washington Health Project Commission of the Washington State Legislature, July 1986.

"Changing Health Policy in a Changing Environment." Testimony before Washington State Senate Committee on Human Services and Corrections, July 1986.

"Allied Health Professions in Public Policy," Seattle Community College Conference for Allied Health, September 1986.

"Rural Health Services in the WAMI Region," American Public Health Association Annual Meeting, Las Vegas, Nevada.

"Washington Health Policy, "American Business Women, Seattle Chapter, October, 1986.

"The Uninsured and the McPhaden Commission," Presentation to the University of Washington Hospitals, November 1986.

"The McPhaden Commission and Managed Care for the Indigent," presentation to the American College of Health Executives, Seattle chapter, November 1986.

"Health Insurance for the Uninsured" presentation to the Stanford Research Institute Conference on Private Sector Involvement in Health Care, Palo Alto, California.

"Prospective Payment for Physicians," Society of Anesthesiologists Annual Seafair Meeting, July 1987.

"Health Care Access," Secretary's Seminar in Health Policy, April 1987.

"Health Policy in the 1990's," Washington State Nurses Association 1987.

"Financial Status of Rural Hospitals," WSHA Rural Hospital Workshop, Chelan, July 1987.

"Mandated Benefits in Perspective," Symposium sponsored by State Health Coordinating Council, November 1987, Seattle.

"Rural Health: Issues and Policies," WAMI Legislative Conference, December 1987.

"Prenatal Care in Washington," presentation to board of Children's Hospital and Medical Center, January 1988.

"Financial Issues of the Elderly," Aging and the Elderly Review Course, sponsored by UW School of Medicine, February 1988.

"An Evaluation of Prenatal Care in Washington," Rural Health Strategies Conference, Spokane, March 1988.

"Obstacles to Service Delivery: A Response," The Duncan Seminary, April 1988.

"The Economic Environment Facing Rural Hospitals," Rural Health Policy Commission, Washington State Legislature, May 1988.

"Geriatrics Financing Options,: Economic Considerations in Geriatric Oral Health Care, Symposium, Case Western Reserve, May 1988.

"Health Policy Choices for the 1990's: What Can We Afford?", testimony before Health Committee, Washington State Senate, June 1988.

"Legislative Strategies for Uncompensated Care," Sisters of Providence, January 1989.

"Policy issues for the Uninsured: The Washington Basic Health Plan," seminar for Department of Community Dentistry, April 1989.

"The Basic Health Plan: A Tale of Great Expectations," Seminar for the Department of Health Services, Spring 1989.

"The Public Benefit in Public Health," Snohomish Health District, July 1989.

"Washington's Basic Health Plan," American Public Health Association Meetings, October 1989.

Panel Moderator, Employee Benefits Planning Association Annual Meeting, May 1990.

"Measuring the Uninsured," Association for Health Services Research Meeting, June 1990.

Panel Moderator, American College of Health Executives, June 1991.

"Health Policy Issues of the 1990s," Horizon House, Seattle, WA, October 1991.

"Health Policy and Health Care Reform," Seattle Women Economists, Seattle, WA, October 1991.

"Issues of Biased Selection in the Basic Health Plan," School of Public Health, University of Minnesota, Minneapolis, MN, March 1992.

"The Black Hole Theory: Selection in Washington's Basic Health Plan," Department of Health Services, University of Washington, Seattle, WA, April 1992.

"Health Care Reform from the Consumer's Perspective", Medical Managers' Association, Seattle, WA, April 1992.

"Health Care Reform: A Marketing Perspective", Medical Marketing Association, Seattle, WA, May 1992.

"Health Policy Lessons from Abroad," University of Puget Sound Health Lawyers Conference, Seattle, WA, May 1992.

"Health Care Reform: Tempest in a Teapot?", Department of Economics External Steering Committee, Seattle, WA, May 1992.

"Evaluation Update", Basic Health Plan Advisory Council, Seattle, WA, June 1992.

"The Federal Reserve Board: Health Care Analogy?", Washington State Hospital Association Board of Directors, Seattle, WA, June 1992.

"Health Care Reform Issues and Alternatives," Washington State Osteopathic Association, Blaine, WA, June 1992.

"Governor Candidates: Health Care Reform Platforms" (panel moderator), Patient Accounts Managers Association, Bellevue, WA, June 1992.
"Health Care Reform: Tempest in a Teapot?" University of Washington Board of Regents, Seattle, WA, July 1992.

"Fifty Paths to Reform" Conference sponsored by Indiana University School of Medicine, Indianapolis, October 1992.

"The Future of Health Care," Virginia Mason Continuing Education Program for Nurses, Seattle, March 1993.

"Health Care Reform: History and Future" Conference sponsored by Business and Professional Institute, Seattle, May 1993.

"Health Care Reform: What's in Store?" Washington Neurological Association of Neurological Surgeons, Annual Meeting, Chelan, June 1993.

"Revolution, Reform, and Research: The University and the 3R's," School of Public Health & Community Medicine Visiting Committee, November 10, 1993.

"Managed Care in Perspectives: Where Are We and How Did We Get Here?," Washington State Chest Conference Lung Day, January 1994, Leavenworth, WA.

"The Future of Health Care Reform," Methow Valley Speaker Series, Winthrop, WA, October 1994

"Health Care and Ecological Economics," Lakeside School, Seattle, WA, November 1994.

"Report of the Task Force on Medical Savings Accounts,' Health Services Commission, Olympia, WA, December 1994.

"Overview of the Performance of the U.S. Health System," with Aaron Katz, Senate Health and Long Term Care Committee, Olympia, WA, January 1995.

"Lessons from the Basic Health Plan Evaluation," Group Health Center for Health Studies, Seattle, WA, March 1995.

"Health Care Economics in a Rural Environment." Fairbanks Memorial Hospital, Fairbanks, AK. April 1999.

VIDEO PRESENTATIONS

Washington Health Choices video project, Puget Sound Health Systems Agency, 1986.

PROFESSIONAL ACTIVITIES

CONSULTING

Member of site visit team and proposal review for study of Veterans Administration Hospital, New Haven, Connecticut, Veterans Administration, January 1977.

Project report review for Arthur Andersen study of Hospital Based Physicians, July 1977. University Hospital Study of Case-Mix Related Costs, 1977-1978.

Department of Social and Health Services, State of Washington, Consultant in Nursing Home Suit, 1978.

California Health Facilities Commission, 1978-1979.

Health Care Financing Administration, Study of Implementation of 223 Limits, 1979.

Development and presentation of ASTI course on rate regulation with Jay Glasser (University of Texas) and Frank Baker.

Blue Cross of Louisiana, Hospital Classification for Prospective Reimbursement, Summer 1981.

Blue Cross of Louisiana, helped develop hospital classification system for Louisiana hospitals, Summer 1981.

Commission on Professional and Hospital Activities, Economies of Scale project funded by Health Care Financing Administration, 1982-1983.

Hogan and Hartson, New York State Nursing Home suit, September 1982.

DRG Waiver Proposal, Hospital Council of Northern California, Summer, 1984.

Texas Department of Mental Health and Mental Retardation, Alternative prospective financing schemes, Winter 1985.

Bennett and Bigelow, Certificate of Need Appeals, 1985.

Office of the State Attorney General, State of Washington, Price fixing in Physician Controlled Insurance Companies, 1984-85.

Washington State Hospital Association, reimbursement regulation issues, 1986.

Overlake Hospital, certificate of need application, 1986.

American Medical Research Review Committee, workshop presentation for national PRO organizations, Washington, D.C. 1987.

Sisters of Providence, Legislative Strategies Project, 1989.

Snohomish Health District Public Health Funding Project with Arthur Andersen, 1989.

COMMUNITY SERVICE

Assisted Puget Sound Health Systems Agency on grouping hospitals for planning purposes, Summer 1980.

Assisted Virginia Mason Hospital to clarify case-mix classification system, Summer 1980.

Group Health Cooperative of Puget Sound, planning committee member, 1980-1981.

Member, Citizens Forecast Committee, Seattle City Light, 1982-1983.

The Mason Clinic, Coping with Prospective Payment.

Puget Sound Health Systems Agency, Planning Committee for Conference on Managed Health Care, 1985.

Washington State Public Health Association, conference program planning committee.

Washington State Legislature, 1985-87:

- study of the state's role in public health, Joint Select Committee on Public Health
- certificate of need, House of Representatives staff
- financing alternatives for waste clean-up, Parks and Ecology staff
- financing of services for developmentally disabled children, Department of Developmental Disabilities
- sunset reviews of midwifery, drugless healers, chiropractors
- Chair, Technical Advisory Committee A to the Washington Basic Health Project Commission
- Public Health Policy Task Force, Washington State Senate
- Miscellaneous testimony on health policy issues, Washington State Legislature
- Prenatal Care Program Evaluation, Office of Parent and Child Health, 1986-87

Washington State Department of Justice Novack Commission on Tort Reform, 1987-88.

Advisory Committee to the Washington Rural Health Committee, Washington State Legislature.

Panel Chair, Health Systems Resources Legislative Conference, December 1987.

Facilitator, Washington State House of Representatives Conference on Long Term Care, 1987.

Consultant, Legislative Budget Committee Sunset Review of Hospital Cost Commission.

Member, Technical Advisory Committee to Rural Health Policy Commission, Washington State Legislature, 1988.

Consultant, Department of Labor and Industries, 1989.

Member, Task Force on Medical Savings Accounts, Washington Health Care Commission, 1994.

Consultant, St. Clare Hospital, Lakewood, Wa. 2001.

TEACHING

Executive Program in Health Administration, University of Colorado (Denver), Program Evaluation Course, 3 credits,
100% responsibility, 25 students, 1989.

Executive Program in Health Administration, University of Colorado (Denver), Health Policy and Economics Course, 3 credits,
100% responsibility, 15 students, 1991.

Healthcare Management Institute, 2-day Health Economics seminar for Mercy Hospital physicians, San Diego
100% responsibility, 30 students, 1992.

Management Education and Development Series, American College of Medical Practice Executives, 2 day Health Economics module, Marshfield, WI, November 1994.

Executive Program in Health Administration, University of Colorado (Denver), Health Policy and Economics Course, 3 credits, 100% responsibility, 11 students, 1993.

Executive Program in Health Administration, University of Colorado (Denver), Health Policy and Economics Course, 3 credits, 100% responsibility, 10 students, 1995.

FUNDED RESEARCH IN PROGRESS

"State Planning Grant on Access to Health Insurance." Co-investigator. Aaron Katz and Susan Marquis, PI's. $852,829. Washington State Office of Financial Management. July 2001 – February 2002.

"Community Health Tracking Study." Co-investigator. Aaron Katz, PI. $ July 2000 – March 2002.

"Home Care Research Initiatives Grant: National Study of Home Care - Assisted Living Connection." Rosalie Kane, PI. The Robert Wood Johnson Foundation. (consultant)

"Multi-State Evaluation of Dual Eligible Programs." (subcontract) Robert Kane, PI. $ 8,635. Health Care Financing Administration.

RESEARCH PROPOSALS PENDING

"Insurance Financing of Integrated Medicine." Co-investigator. Bill Lafferty, PI. Submitted to NIH. $1,050,000. July 2001 – June 2004.

FUNDED RESEARCH: COMPLETED PROJECTS

"A Review of Certificate of Need." Aaron Katz, PI. $50,000. Joint Legislative Audit and Review Committee. Co-investigator.

"Crime Victims Compensation Program Evaluation," C.W. Madden and Aaron Katz, Co-PI's, $50,000. Washington State Department of Labor and Industries.

"Managed Care Monitoring and Evaluation Project," C.W. Madden & Robert Crittenden, Co-PI's, Interagency agreement with Health Care Authority under Robert Wood Johnson Foundation Grant, $75,000, 12/15/93 - 6/15/94

"Health Services Utilization of the Previously Uninsured," C.W. Madden, P.I. Subcontract to University of Southern Maine proposal to R.W. Johnson Foundation $540,392. 11/91-2/94.

"Issues in Hospital Classification and Reimbursement," T.D. Klastorin and C.A. Watts, Co-PIs, Health Care Financing Administration, $422,223, 1981.

"A Study to Develop and Test Measures of Case Mix Complexity for Hospitals", T.D. Klastorin and C.A. Watts, Co-PI's, (subcontract to CPHA) Health Care Financing Administration, $50,000, 1980.

"A Randomized Trial of Liaison Psychiatry in Primary Care," 10% (NIMH, economist)

"Health Insurance for the Low Income: An Evaluation," C.W. Madden, P.I. $1.2 million 2 1/2 years, funded by NCHSR.

"Economic Analysis of Proposed Water Quality Standards," IPPM, $20,000, 5% economist, funded by Washington Department of Ecology.

"Evaluations of Sound Care Plan", Washington Department of Social and Health Services, $81,000, 1989 and 1991, C.W. Madden, P.I.

"Evaluation of Community Access Program," Washington Department of Social & Health Services, $110,000, 1991. C.W. Madden, P.I.

"Evaluation of KPS Waiver Program", C.W. Madden, PI, Washington Department of Social and

Health Services, $56,962, 1993.

"Sun Valley Forum," Robert Wood Johnson Foundation, $80,000, 2/92-9/92.

"Health Care Cost Commission," $79,000, State of Washington and Henry J. Kaiser Foundation, 6/90-12/92.

"Evaluation of Selective Contracting Program," Washington Department of Social and Health Services, $55,663, 2/92-8/92

"The Cost of Foodborne Disease," C.W. Madden, P.I., $25,000, USDA.

"Health Insurance for the Low Income: Competing Renewal," C.W. Madden P.I., $1.2 million (direct), 2 1/2 years, AHCPR, (3/91-9/93).

"Medical Risk Distribution Among Competing Health Plans," C.W. Madden and Margaret Stanley, Co-PI's, $650,000, Robert Wood Johnson Foundation. 11/1/93 - 8/31/95.

"Healthy Options Statewide Evaluation," Aaron Katz, PI., 3% investigator, Washington Department of Social and Health Services, $148,419, 2/1/95-6/30/95.

"An Evaluation of Medicaid Extension Demonstration in 3 states, (subcontract to Health Economics Research)," C.W. Madden, PI, Health Care Financing Administration, $228,210 (total $1,425,000), October 1992 - September 1997.

"Evaluation of the Worker's Compensation Managed Care Pilot Project," Tom Wickizer, PI, 5% investigator, Washington Department of Labor and Industries, $347,145, 8/15/94-3/31/96.

"Effects of Physician Compensation on Physician Behavior," Doug Conrad, PI, 10% investigator, Robert Wood Johnson Foundation, $624,048, 2/1/95-10/31/96.

"Community Snapshots," Aaron Katz, PI., 10% investigator, Robert Wood Johnson Foundation, $167,613, 2/1/95-9/30/95.

"Washington State Health Services Commission," Aaron Katz, PI, 3% investigator, $15,000, 4/1/94-6/30/95.

"An Evaluation of Medicaid Extension Demonstration in 3 states, (subcontract to Health Economics Research)," C.W. Madden, PI, Health Care Financing Administration, $228,210 (total $1,425,000) October 1992-September 1997.

"Hospital Diversion and Use of Psychiatric Hospitals," J. Semke PI, 1% consultant, NIMH, 10/93-9/98.

"Implementation of Diagnostic Risk Adjustment in an Employed Population," C.W.Madden, PI (25%), Robert Wood Johnson Foundation, $1,053,719, 8/1/95-12/31/97.

"Health Status Based Risk Adjustment for a Medicaid SSI Population", C.W. Madden, PI. (10%),

Robert Wood Johnson Foundation, $89,604, 8/1/96-7/31/97.

"Using the CCHC Classification to Assess Health Status for Risk Adjustment." C.W. Madden, PI. $24,161. Children's Hospital and Medical Center.

"Use of CCCHC for Risk Adjustment of Capitation Payments." C.W. Madden, PI. $59,990. Center for Health Care Strategies.

UNIVERSITY SERVICE

Alternate, Committee on Legislative Affairs, 1988
Alternate, Graduate Program Coordinator, 1989
Faculty Senate representative, 1985-87
Chair, Ad Hoc Committee for Establishing Criteria for Progress of Research Associates, July 1988.
Chair, MHA Program Director Selection Committee 1990
Member, Faculty Affairs Committee, Graduate School of Public Affairs, 1989-90.
Member, Committee to Evaluate Health Services Chairman, 1989-90.
Member, Department of Health Services Curriculum Committee, 1990-91.
Member, Social Services Gateway Committee, Graduate School of Public Affairs, 1990-1994.
Member, MHA Birthday Party Planning Committee, 1991-92.
Member, Health Economics Committee Field Exam, 1992
Member, School of Public Health and Community Medicine Promotion and Tenure (Faculty Affairs) Committee, 1992-1994.
Member, Search Committee for Chair of Department of Health Services. 1994.
Chair, Task Force on MHA Policy Curriculum, 1995.
Member, Advisory Committee of the Center for Medical Education Research, 1995.

Valley Hospital Administration
950 E. Bogard Road, Ste. 218
Wasilla, AK 99654
Phone: (907) 352-2860
FAX: (907) 352-2865

FAX COVER SHEET

DATE: 4-2-02

TO: Rep. Fred Dyson

COMPANY: ______ FAX: ______

FROM: E. Ripley PHONE: 907-352-2860
Valley Hospital FAX: 907-352-2865

Number of pages including cover sheet: 4

Subject:

Please accept this written response from Valley Hospital to your questions posed on 3/28 during public testimony for HB 407. Thank you.

****

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MEMO

TO: Representative Fred Dyson, Chair, House HESS Committee

FROM: George Larson, CEO, Valley Hospital Association

RE: Your questions regarding Valley Hospital rates and not-for-profit status

Per your questions to Elizabeth Ripley, Valley Hospital spokesperson, at the March 28 HESS committee meeting, please consider the following response. In your first question, you asked if a level playing field were possible when for-profit healthcare institutions pay taxes and not-for-profit hospitals do not. As a not-for-profit hospital association, VHA feels a great obligation to provide benefit to the community that exceeds the amount VHA would have paid in local, state and federal taxes.

Community benefit can be measured by the hundreds of thousands of dollars VHA contributes in "charity care" to those who cannot afford to pay for services rendered. The Mat-Su community benefits from the substantial monies VHA writes off in uncollectable accounts, discounts, and adjustments that number in the millions of dollars annually. VHA provides many services like health education and promotion, for which reimbursement does not equal the cost to provide those services.

We invest 10% of our net revenues in excess of expenses back into the Mat-Su Borough community through our Healthy Communities Program. This Healthy Communities Program makes small community grants to local organizations and funds programs throughout the Mat-Su Borough that help to raise health status of Valley residents. Nationwide, most hospitals invest less than one-percent back into the community, and Valley Hospital has been recognized for its leadership in this area. In the final analysis, we are confident that VHA gives back much more than the amount it would have paid in taxes.

Your second question asked about Valley Hospital's rates and if we charge the same rate for the same services to all financial classes. We do offer preferred provider discounts to organized groups in return for that group's guarantee that payment will be made for services provided to a specific population segment that typically numbers in the hundreds or thousands of people. Patients without insurance do not have the benefit of negotiating for hundreds or thousands of people. Still, we offer them a four-percent discount up front by paying at the time of service for both inpatient and outpatient care.

While all for-profit and not-for-profit institutions construct these preferred provider agreements with insurance brokers and the state and federal government, they do not universally extend such a generous discount option to patients without any form of insurance. In addition to this, Valley Hospital offers "self pay" clients payment plan arrangements that are interest free. In 2001, for self-pay billed charges, Valley Hospital received approximately 15 cents for every dollar billed. Of total billed charges, we annually write off seven percent in bad debt and two percent through our aggressive charity care program. This unreimbursed care totaled $3,974,000 in 2000 and $5,501,000 (unaudited) in 2001.

If you have further questions or would like to discuss Valley Hospital and our position on the CON, please do not hesitate to contact me at 907-352-2860.

515 E. DAHLIA ST., P.O. BOX 1687, PALMER, AK 99645 (907) 746-8600

MEMO

TO: Representative Fred Dyson, Chair, House HESS Committee
Members of House HESS Committee

FROM: George Larson, CEO
Valley Hospital Association

RE: Written Testimony for House Bill No. 407

For the record, Valley Hospital Association is against the proposed population delimiter in House Bill No. 407 and Senate Bill 256. Valley Hospital serves one of the only large communities in the state that would be affected by this proposed population delimiter for the Certificate of Need process.

Valley Hospital supports other measures in these bills, including the following:

- Leaving the CON at the $1,000,000 level
- Replacing facilities at the same site or in the same community as long as no new category of health services is provided and the existing facility is not used for other health services without a CON
- Adding time requirements and review standards for the CON department to process CON applications

We acknowledge the benefits of fair competition, and assert that this proposed delimiter does nothing to support a level playing field. We are particularly concerned about the establishment of "medical boutiques" (such as a free-standing imaging or surgery center) that limit services to those without third party insurance, thereby "cherry-picking" most of the paying customers. The demography and geography of Alaska limit the effectiveness of unregulated competition as a means of ensuring socially appropriate supply and demand of health care services.

To put this "cherry-picking" in perspective, the Mat-Su Borough has one of the highest rates of Medicaid patients, per capita, of any borough in the State of AK. Medicaid is the fast growing "payer segment," along with "self-pay"—those that do not have any insurance. In the last three months, Valley Hospital's "self-pay" financial class has doubled from eight percent to 12% of our payer mix. In the next five to 10 years, we expect our Medicare payer segment to double from six to 12 percent of our population. In Mat-Su, there are already private providers that do not accept or limit the number of Medicaid or Medicare patients that they see. Based on what is already happening, we cannot assume that these "medical boutiques" will treat patients in these payer groups that do not pay 100 cents on the dollar.

Valley Hospital is legally and ethically bound to serve all patients that walk through our doors, regardless of ability to pay. Under EMTALA, Valley Hospital cannot turn anyone away or discharge him or her due to financial class. A "medical boutique" does not operate under the same regulations and may in fact limit customers of a particular payer status (Medicaid, Medicare or self-pay).

515 E. DAHLIA ST., P.O. BOX 1687, PALMER, AK 99645 (907) 746-8600

Valley Hospital is a private business, a not-for-profit enterprise, and receives no assistance from the Mat-Su Borough government, which has limited health powers as a second class borough. Valley Hospital competes directly with the Anchorage providers (Alaska Regional and Providence). Over 16,000 Valley residents commute to Anchorage for work Monday through Friday. Surveys conducted by Valley Hospital show that most of these commuters receive their healthcare in Anchorage and use Anchorage providers. Over the last five years, Valley Hospital has made between 1.5 and 2.5 million dollars in net revenues. As you can see, Valley Hospital is in a competitive environment.

At Valley Hospital, our board members and administrators take seriously the intent and spirit of the [illegible] code. We invest 10% of our net revenues in excess of expenses back into the Mat-Su Borough community through our Healthy Communities Program. This Healthy Communities Program makes small community grants to local organizations and funds programs throughout the Mat-Su Borough that help to raise health status of Valley residents. Nationwide, most hospitals invest less than one- percent back into the community, and Valley Hospital has been recognized for its leadership in this area.

In addition, Valley Hospital reinvests the remaining 90% of its revenues back into capital equipment, facilities and staffing to remain competitive and viable. Each year, Valley Hospital strives to donate one percent of its net revenues to charity care. This, coupled with uncollectible accounts, adds up to millions of dollars annually in unreimbursed care. This unreimbursed care totaled $3,974,000 in 2000 and $5,501,000 (unaudited) in 2001.

In summary, Valley Hospital supports keeping the Certificate of Need at a $1 million threshold for equipment and raising the CON to a $2 million threshold for building, so long as any bill altering the CON also supports the following criteria:

- All providers, including private physicians, must meet the terms of the CON.
- All providers must provide care for all financial classes, and their payer mix must reflect the payer mix of the locale within which they operate. (Note: the current CON bureaucracy at the State could track this.)
- All expenditures, whether they be for capital, equipment, operational lease, or bricks and mortar, must fall under this $2 million threshold.

With such great controversy over this proposed amendment to the CON, we recommend that the legislature establish a working group comprised of providers and legislators to examine the entire CON process. Valley Hospital remains willing to work with interested parties and the State of Alaska to improve the CON process in order that it respond to the evolving needs of the health care environment in Alaska.

Compilation of Comments on the Failure of CON Laws

Excerpted from "*BEYOND HEALTH CARE REFORM: RECONSIDERING CERTIFICATE OF NEED LAWS IN A MANAGED COMPETITION SYSTEM*"
By PATRICK JOHN MCGINLEY
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CON laws evolved from the health care reforms of the 1940s and were heavily promoted well into the 1970s by health care providers, who found CON effective in sheltering their businesses from the costly effects of a competitive marketplace. Congress mandated CON in 1974, but quickly repealed the mandate when CON failed to lower the nation's health care costs.

"In one comparison of health care prices and expenses, it was shown that such prices and expenses are actually higher in areas with CON regulations than they are in areas without CON."[1] In fact, national hospital care expenditures increased from $52.4 billion when Congress enacted the 1974 National Health Act to an estimated $230.1 billion in 1989.[2] Today, Americans are spending nearly a trillion dollars annually on health care.[3] In searching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering health care costs.[4] CON "has elicited a remarkable evaluative consensus—that it does not work."[5]

CON, in addition to failing to decrease national health care expenses, was having detrimental effects on the provision of health care in local communities. The effect of CON on local communities was perhaps best related to Congress by the words of Representative Rowland of the Eighth District of Georgia. Representative Rowland recognized that CON appeared to be a good idea in theory, yet in reality failed to control health care costs and was often insensitive to community needs. ("At first glance, the idea [of certificate of need] may have looked pretty good. In practice, however, the effect of certificate-of-need on health care costs has been dubious, at best. And the program has certainly been insensitive in many instances to the true needs of our communities.") [6]

One may question the wisdom of continuing any form of state regulation that failed to produce its desired goal when implemented nationwide.[7] As the review of Congress's intent indicates, CON had one goal—to save money. However, in those states which retained their CON laws, the retention was often supported by new and creative justifications, many of which were unrelated to saving money. Commentators, in their traditional role of explaining the reason behind events, have set forth many justifications explaining why states have kept the same old CON laws.[8] All these justifications, however, are the crafty work of commentators, and not the motivation of state legislatures. No state legislature has codified any of these new justifications as legislative intent.[9] These justifications should therefore carry little weight in a proper analysis.[10]

Where certificate-of-need laws limit resources effectively, the owners of existing facilities are in a seller's market. They can charge inflated prices for their facilities,..... [C]ertificate-of-need laws will continue to raise health care costs by restricting the entry of cost-effective providers into the market.[11].

1. Mark E. Kaplan, Comment, *An Economic Analysis of Florida's Hospital Certificate of Need Program and Recommendations for Change*, 19 FLA. ST. U. L. REV. at 487 (1991).
2. *Id.* at 487 n.102.
3. Clark C. Havighurst, *Contract Failure in the Market for Health Services*, 29 WAKE FOREST L. REV. at 47. (1994).
4. One author contends that the proper evaluative analysis is not whether certificate of need succeeded in lowering the nation's health care costs, but whether it thwarted the rate of increase in the nation's health care costs. *See* Kaplan, *supra* note 1, at 487. That author concedes, however, that certificate of need is a failure even under his alternative analysis. *Id.*
5. *Id.* (quoting Lawrence D. Brown, *Common Sense Meets Implementation: Certificate-of-Need Regulation in the States*, 8 J. HEALTH POL., POL'Y & L. 480, 481 (1983)).
6. 134 CONG. REC. H9455-01 (1988)
7. For legislators, wisdom can sometimes fall prey to lobbyists. For example, the Texas Medical Association was instrumental in reinstating certificate of need laws after the Texas legislature repealed the regulations. *See Statelines—Texas: Certificate-of-Need Program Reinstituted*, 1 AMERICAN HEALTH LINE, June 16, 1992. In New Jersey, a coalition of twenty urban and teaching hospitals demanded that certificate of need laws not be repealed, warning that deregulation could force hospitals out of business, and stating that they were "concerned there is a push to a deregulated environment." *Statelines—New Jersey: Many Hospitals Fear Deregulation*, 1 AMERICAN HEALTH LINE, Nov. 19, 1992. Likewise in Georgia, the Atlanta Health Care Alliance says it has "supported the certificate-of-need law and health-planning regulations . . . . Duplicative, unnecessary health-care services have been very costly to our members." *Access, Quality, Cost—Cost Containment: Regulation "Back into Vogue,"* 1 AMERICAN HEALTH LINE, May 11, 1992. *See also* Clark C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 VA. L. REV. 1143, 1148-51 (1973) [hereinafter Havighurst, *Regulation by CON*], at 1216 (noting that "avoidance of 'duplication' is of course consistent with a cartel's preference for minimizing competition"). Hospital lobbyists demand the protection of certificate of need, because "business coalitions . . . see planning as a way to control costs for their members." *Access, Quality, Cost — Cost Containment: Regulation "Back into Vogue"*, 1 AMERICAN HEALTH LINE, May 11, 1992 (quoting James Kimmey, Dean of the School of Public Health at St. Louis University).

Hospitals are aware that, instead of controlling costs (or "revenue" as seen from the hospital's perspective), certificate of need had the opposite effect. *See supra* part I.B.2. "Viewed in the light of possibilities for more fundamental changes in the market for insurance and health services, certificate-of-need laws may appear as conservative measures, designed to preserve the very institutions [that] create the problems to which they are addressed." *See* Havighurst, *Regulation by CON*], supra note 6, at 1156. Hospitals therefore fight to keep certificate of need alive.

8. *See generally* Kaplan, *supra* note 1; Maja Campbell-Eaton, Note, *Antitrust and Certificate of Need: A Doubtful Prognosis*, 69 IOWA L. REV. 1451, 1453 (1984).; Scott D. Makar, *Antitrust Immunity Under Florida's Certificate of Need Program*, 19 FLA. ST. U. L. REV. 149, 150 (1991); Bruce Babbitt & Jonathan Rose, *Building a Better Mousetrap: Health Care Reform and the Arizona Program*, 3 YALE J. ON REG. 243 (1986); Norman Daniels, *Technology and Resource Allocation: Old Problems in New Clothes*, 65 S. CAL. L. REV. 225 (1991); Mark A. Hall, *Managed Competition and Integrated Health Care Delivery Systems*, 29 WAKE FOREST L. REV. 1, 2 (1994); Carl J. Schramm & Steven C. Renn, *Hospital Mergers, Market Concentration and the Herfindahl-Hirschman Index*, 33 EMORY L.J. 869, 881 n.30 (1984) ("[H]istorically, demonstrating 'need' has often been an easy task, and less than one-quarter of all proposed projects fail to win planning agency approval."). The Supreme Court has held that "need" is not an unconstitutionally vague standard in regulatory statutes; John A. Robertson, *Asking the "Woman Question" About Health Care Reform*, 3 TEX. J. WOMEN & L. 1 (1994); David M. Frankford, *Privatizing Health Care: Economic Magic To Cure Legal Medicine*, 66 S. CAL. L. REV. 1 (1992). Examples of new justifications for old certificate of need laws include curbing "excessive competition," solving a "moral hazard," rectifying "inadequate information," and eliminating "inefficient incentives." *See, e.g.*, Kaplan, *supra* note 1, at 479-84. The true reasons for retaining CON are far more pragmatic. *See supra* note 6.
9. *E.g.*, CODE OF ALABAMA §§ 22-21-260 to 278 (1994); ALASKA STAT. §§ 18.07.021-.111 (1995); CAL. HEALTH & SAFETY CODE §§ 437.10, 439.7 (1995); CAL. GOV'T CODE § 15438.1 (1994); CONN. GEN. STAT. §§ 19a-154 to 155 (1994) (licensing and budget review law); 16 DEL. CODE ANN. §§ 9301-11 (1994); D.C. CODE ANN. §§ 32-326 (1981); FLA. STAT. ch. 408 (1993 and Supp. 1994); GA. CODE ANN. §§ 31-6-1 to 70 (1994); HAW. REV. STAT. §§ 323D-1 to 54 (1989); IND. CODE ANN. §§ 16-29-1-1 to 16 (Burns 1994) (expiring July 1, 1996 pursuant to IND. CODE ANN. § 16-29-1-16); IOWA CODE §§ 135.621-.73 (1994); KAN. STAT. ANN. §§ 65-4802 to 4822 (1992); KY. REV. STAT. ANN. §§ 216B.010-.310 (Baldwin 1994); ME. REV. STAT. ANN. tit. 22, 301-24 (1994); MD. CODE ANN., HEALTH-GEN., 19-101 to 222 (1994); MICH. COMP. LAWS §§ 333.22201-60 (1995); MISS. CODE §§ 41-7-171 to 209 (1995); MO. REV. STAT. §§ 197.30-.65 (1995); MONT. CODE ANN. §§ 50-5-301 to 316 (1994); NEB. REV. STAT. §§ 71-5801 to 70 (1994); N.H. REV. STAT.

ANN. §§ 151-C:1 to 15 (1994); N.J. REV. STAT. §§ 26:2H-1 to 2I-39 (1994); N.C. GEN. STAT. §§ 131E-175 to 190 (1994); N.D. CENT. CODE §§ 23-17.2-01 to 15 (1993); OHIO REV. CODE ANN. §§ 3702.51-.60 (Anderson 1995); OKLA. STAT. tit. 63, 1-850 to 858 (1995); OR. REV. STAT. §§ 442.58-.86 (1992); 35 PA. CONS. STAT. §§ 448.701-.712 (1995) (expiring 1996); S.C. CODE ANN. §§ 44-7-320 to 460 (Law. Co-op. 1976); TENN. CODE ANN. §§ 68-11-101 to 125 (1994); VT. STAT. ANN. tit. 18, 9431-44 (1994); VA. CODE ANN. §§ 32.1-102.1 to 102.11 (Michie 1994); V.I. CODE ANN. tit. 19, 223 (1994); WASH. REV. CODE §§ 70.38.015-.920 (1995); W. VA. CODE §§ 16-2D-1 to 15 (1995)..

10. A proper analysis of certificate of need should focus on the benefits of a regulated bed supply. After all, the purpose of certificate of need regulations is to control the size and growth of the bed supply. *See* discussion *supra* parts II.A., II.B. Therefore, to properly evaluate certificate of need laws, the effect of CON bed supply controls should be measured against the resulting increase or decrease in health care prices.

Regulatory restraint on the growth of bed supply will result in somewhat higher prices than an unregulated marketplace would produce no matter how well the health care industry is regulated. Havighurst, *Regulation by CON, supra* note 4, at 1218. Certificate of need laws monitor only certain kinds of hospital costs, and therefore "may merely divert inflationary pressures and achieve no control." *Id.* In many instances, this diversion leads to a higher price for health care. For example, imagine two hospitals, one regulated by certificate of need, the other unregulated. Further imagine an unexpected increase in hospital wage costs. *Id.* (revealing that this type of event is rather common in the health care industry by stating that increases in hospital wages and "other types of cost increases . . . are equally likely to occur"). The unregulated hospital has the opportunity to add beds and thereby allocate the increase in wage costs over a greater number of patients, resulting in a smaller increase in health care cost per patient. *See id.* The regulated hospital, however, cannot add beds because of certificate of need regulations. *See id.* (implying that, when a hospital's bed supply is fixed, then its maximum revenue is fixed, even though maximum costs are not). The regulated hospital must allocate the increased cost to a smaller number of patients, resulting in a larger increase in health care costs per patient. In that case, a hospital would face increased costs because certificate of need laws do not regulate wages, yet the hospital would experience no increase in revenue because certificate of need has capped the hospital's maximum revenue. Certificate of need, therefore, can prove rather costly to individual patients.

11. Peter P. Budetti, *Public Policy Issues Surrounding Certificate of Need*, 1978 UTAH L. REV. at 44-45.

Additional comments on the Failure of CON and the value of Competition

"Health facilities exist to serve the public. How is the public served by a virtual monopoly over this most critical of all public needs"? *Former Mississippi Governor Kirk Fordice, in an address to the Mississippi Legislature, 1999, from the Mississippi state web page (wwwvgovoff.state.ms.us/main/gc/gc020299.html);*

"CON laws, born out of an effort to control cost, may actually increase health care costs by suppressing competition, as noted by Department of Health Executive Director Dr. Ed Thompson in his 1995 response to PEER questions. A Daniel N. Mendelson and Judith Arnold study, based on extensive empirical analysis of hospital costs, concluded that CON programs have not held down hospital costs. These researchers also found no evidence of increased costs in the initial twelve states that repealed CON requirements." *Ibid.*

"According to the FTC complaint detailing the charges in this case, the [*ambulatory surgery center*] acquisition would violate antitrust laws by substantially reducing competition for outpatient surgery services in Anchorage. The market for these services is highly concentrated, having few competitors, and entry by new entities is difficult because of state certificate-of-need requirements, the complaint states. Thus, the FTC alleged, it is unlikely that, absent the divestiture required by the settlement, a new competitor could be established quickly enough to deter any anticompetitive behavior by Columbia/HCA. Moreover, the acquisition could increase the probability of collusion among remaining sources of outpatient surgery in the market and could, therefore, deny patients and others the benefits of competition based on price, quality and service for outpatient surgery services in Anchorage." *Press release from the Federal Trade Commission, September 15 1995, as listed on the FTC web site (www.ftc.gov/opa/predawn/F95/columbia-mca.htm);*

FEDERAL TRADE COMMISSION ECONOMICS STUDY FINDS CERTIFICATE-OF-NEED REQUIREMETNS INCREASE HOSPITAL PRICES AN COSTS

Consumers Benefit from Hospital Competition

"Certificate-of-need (CON) requirements, which were intended to control health-care costs, have actually increased hospital prices by four percent, according to a study issued today by the Federal Trade Commission's Bureau of Economics." *Press release from the Federal Trade Commission, May 5 1987, from the web site (www.ftc.gov/opa/predawn/F87/hospitals.txt):*

"In addition, the study found, hospital expenses are higher in states that have CON laws. According to the study, "There is no evidence that CON laws have resulted in the resource savings they were purportedly designed to promote." "*Ibid.*

"The study also found that in areas where there are more independent hospitals, consumers get higher quality at the same price because of the increased competition. However, CON laws may be used to reduce the number of hospitals, thereby injuring consumers, according to the Bureau of Economics. "Therefore recent plans and decisions to repeal CON laws in some states should increase consumer welfare," the study states." *Ibid.*

"According to Federal Trade Commission Chairman Daniel Oliver, "Their findings concerning CON laws provide further support for my belief that government restrictions on competition are a major source of consumer injury." " *Ibid.*

"Our regulatory treatment of ASCs recognizes the Department's historical policy of promoting greater utilization of ASCs because of the substantial cost savings to Federal health care programs when procedures are performed in ASCs rather than in more costly hospital inpatient or outpatient facilities." *U.S. Department of Health and Human Services, Federal Register, 11/19/99, (volume 64, number 223), page 38*;

"Many commenters noted that ASCs have saved Medicare hundreds of millions of dollars, forcing hospitals to become more competitive, because ASC payment rates are typically lower than hospital payment rates for the same procedures. Several commenters stated that ASCs foster patient access to care, particularly in medically underserved regions. Moreover, many commenters observed that patients generally prefer outpatient surgical care at an ASC to hospital care. .... We agree that ASCs can significantly reduce costs for Federal health care programs, while simultaneously benefiting patients." *Ibid, page 40;*

".......subsidies to promote the overall financial health of safety net hospitals are determined through often complex allocation mechanisms not directly related to the provision of services, and...... the demarcation of support for public health and specialty services versus care for the poor and uninsured is unclear. He suggests that in order to assure community access to vital public health and specialized services grants should be used to target, financial support for those services essential for community care." *Christine Grant, Chairperson, Commissioner of Health and Senior Services, quoting Darrell J. Gaskin, in Report of the Certificate of Need Study Commission, New Jersey, February 2000*;

"Mr. Havighurst was very critical of CON and supports a totally free market approach to the development of health care facilities and services. He believes CON is poorly conceived and has been responsible for serious policy mistakes that actually increased costs in the health care system;" *Ibid, citing Clark Havighurst, Wm. Neal Reynolds Professor of Law, Duke University School of Law*;

"Mr. Sweeney basically supported deregulation of CON because of the difficulty in balancing market forces and a strong CON program which might limit entry into the market." *Ibid, citing Raymond D. Sweeney, Executive Vice President, Healthcare Association of New York State (HANYS);*

"Ms. Dickson provided an historic overview and analytical analysis of CON. Her analysis indicated that CON does not reduce acute care costs..." *Ibid, citing Pamela Dickson, Senior Program Officer, Robert Wood Johnson Foundation.*

Additional Comments on the Failure of CON Legislation

"A recent study by Georgia State University of 37 papers on CON concluded with this statement "Our review of the research literature indicates that Certificate of Need programs have not only failed to achieve lower hospital costs, but they may have contributed to higher costs, greater inefficiency and lower quality of care. Although there have been no major studies of CON laws in the last five years, the evolution of the healthcare delivery system has removed much of the rational for these programs existence"".[1]

"Certificate of Need is based on the dubious economic theory that increased supply and competition will increase prices" [2]

"Today, thee is no evidence that CON reduces medical cots. In fact, thee is considerable evidence that CON increases the cost of health care. It dose so in three ways:

1) Administrative Costs – The CON program itself imposes substantial costs on both health care providers and the government. Since its inception, federal and state governments have spent more than $1 billion administering the program. For providers, preparing and defending a CON application can be time-consuming and expensive process. Needless to say, the added cost is late passed along to consumers.
2) Lack of competition – CON requirements erect barriers to market entry, thereby reducing competition among health care providers. In effect, existing providers are granted a monopoly. Providers frequently attempt to use the CON process to obstruct would be competitors. The impact of entry barriers is made even worse because the new provider seeking to enter the market is often more innovative and cost-effective than the established providers. Some health care economists estimate that CON barriers to market entry increase hospital costs by as much as 5 percent.
3) Shortages – Where CON requirements have produced a shortage of a particular health care service, prices for those services that are available are certain to rise. At the same time, consumers may be forced to shift to alternative services that are often more expensive.
   The Federal Trade Commission estimates that CON regulations increase the cost of hospital care nationwide by more than $1.3 billion annually.
   Certificate of Need programs also reduce access to health care for those who need it the most.
   It is time to realize that Soviet-style central planning is as big a failure in health care as in all other aspects of the economy. States should repeal their CON requirements".[3]

1. John Steen, Director of the State of Georgia Certificate of Need Program, "*Certificate of Need: A Review*", from the "AHPA Net" web site of the American Health Planning Association, 2001.
2. Michael D. Turner, CATO Institute, Washington, D.C. "*Ending the CON Game*", pg 1, The Heartland Institute: Intellectual Ammunition, Jan – Feb 1996, from the web site, www.heartland.org, 2001.
3. Turner, supra note 2, page 1-2.

'The cost of applying for a CON can be considerable, exceeding $100,000 for major projects. If litigation is required, the cost may reach $300,000...".[4]

"If the (CON) process does not make a significant contribution toward cost containment and equitable distribution of health care resources, and it provides, as some critics suggest, an obstacle to improved health care, it may be that the CON requirements should be abandoned." [5]

"The enormous expenditure of time and money by both administrative agencies and health care provides in complying with the CON process substantially reduces any savings that might be attributable to it. For all its promise, CON review has resulted in the elimination of few projects. Of over 20,000 CON applications reviewed throughout the country between 1979 and 1981, only ten percent were ultimately disapproved." [6]

4. Roberta M. Ross, "*Certificate of Need for Health Care Facilities: A Time for Reexamination*", 7 Pace Law Review 491 (1987), from web site http://php.iupui.edu/~healthw/chapqo~1.htm
5. Ross, supra note 4, page 3.
6. Ross, supra note 4, page 3.

HB407 Testimony

Carl Wales

2 April 2002

Statistics used

- The statistics used in this testimony are shown in accompanying material. The source of that information is shown in the material.

Certificate of Need (CON) Process

- While I have not found a written history which I can quote to support this, it is my understanding that the CON process evolved initially as a requirement of the federal government in hopes that it would control health care costs.
- Many states have realized that it does not serve that purpose so that now 30 % of the states have no CON.

CON Requirements

- Of the ten **least** densely populated states only two have a CON requirement. Of those two, one requires a CON only for counties with a population of over 100,000 and the other requires a CON only for long term care beds.
- Of the top 15 least densely populated states only four require the CON (the two above plus two more).

- Residents of states with high population densities have options/choices by virtue of having lots of facilities.

- This provides choice and drives efficiency in delivering health care.

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- States with small populations need a "free market system" to foster choices and competition.

- Why is Alaska the only one in the top seven least densely populated states with a CON requirement?

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Myth

- "Non-profit" and "Not-for-profit" do not necessarily mean efficient operation of the organization.
- Many "Non-profit" and "Not-for-profit" organizations that are funded through charities are driven to greater efficiency because the donors may donate to other causes (donors have choices).
- Health care organizations (and other types of organizations) that have a monopoly are not driven to be efficient and provide the highest quality– they can exist, and continue to exist, and be inefficient, by virtue of their being the *only* choice no matter how bad the choice is

Carl Wales

- Resident of Fairbanks since 1993.
- I do not work for any part of the health care system.
- I do not own stock in or benefit in any way from the health care industry beyond being a patient.

Accompanying material

- Spreadsheet showing state sizes and populations plus the calculations to determine population density and ranking.
- Chart of states requiring the CON taken from the Community Catalyst web site.

Certifcate of Need shown compared to Population and Size

Rank by Population	State	Population (2000 est.*)	Rank by Size	State	Size (Sq. miles of land**)	Pop Density	Rank by Density	CON	
48	Alaska	626,932	1	Alaska	570,374	1.10	1	Y	
51	Wyoming	493,782	9	Wyoming	97,105	5.09	2	N	
47	North Dakota	642,200	17	North Dakota	68,994	9.31	3	N	
46	South Dakota	754,844	16	South Dakota	77,122	9.79	4	N	
36	New Mexico	1,819,046	5	New Mexico	121,365	14.99	5	N	
39	Idaho	1,293,953	11	Idaho	82,751	15.64	6	N	
35	Nevada	1,998,257	7	Nevada	109,806	18.20	7	Y	18
38	Nebraska	1,711,263	15	Nebraska	76,898	22.55	8	Y	17
34	Utah	2,233,169	12	Utah	82,168	27.18	9	N	
32	Kansas	2,688,418	13	Kansas	81,823	32.86	10	N	
28	Oregon	3,421,399	10	Oregon	96,003	35.64	11	Y	
40	Maine	1,274,923	39	Maine	30,865	41.31	12	Y	
24	Colorado	4,301,261	8	Colorado	103,729	41.47	13	N	
20	Arizona	5,130,632	6	Arizona	113,642	45.15	14	N	
27	Oklahoma	3,450,654	19	Oklahoma	68,679	50.24	15	N	
33	Arkansas	2,673,400	27	Arkansas	52,075	51.34	16	Y	
30	Iowa	2,926,324	23	Iowa	55,875	52.37	17	Y	
31	Mississippi	2,844,658	31	Mississippi	46,914	60.64	18	Y	
21	Minnesota	4,919,479	14	Minnesota	79,617	61.79	19	N	
49	Vermont	608,827	43	Vermont	9,249	65.83	20	Y	
37	West Virginia	1,808,344	41	West Virginia	24,087	75.08	21	Y	
2	Texas	20,851,820	2	Texas	261,914	79.61	22	N	
17	Missouri	5,595,211	18	Missouri	68,898	81.21	23	Y	
23	Alabama	4,447,100	28	Alabama	50,750	87.63	24	Y	
15	Washington	5,894,121	20	Washington	66,582	88.52	25	Y	
18	Wisconsin	5,363,675	26	Wisconsin	54,314	98.75	26	N	
25	Kentucky	4,041,769	36	Kentucky	39,732	101.73	27	Y	
22	Louisiana	4,468,976	33	Louisiana	43,566	102.58	28	Y	

Certifcate of Need shown compared to Population and Size

26	South Carolina	4,012,012	40	South Carolina	30,111	133.24	29	Y	
41	New Hampshire	1,235,786	44	New Hampshire	8,969	137.78	30	Y	
16	Tennessee	5,689,283	34	Tennessee	41,220	138.02	31	Y	
10	Georgia	8,186,453	21	Georgia	57,918	141.35	32	Y	
11	North Carolina	8,049,313	29	North Carolina	48,718	165.22	33	Y	
14	Indiana	6,080,485	38	Indiana	35,870	169.51	34	Y	
8	Michigan	9,938,444	22	Michigan	56,809	174.94	35	Y	
12	Virginia	7,078,515	37	Virginia	39,598	178.76	36	Y	
42	Hawaii	1,211,537	47	Hawaii	6,423	188.62	37	Y	
1	California	33,871,648	3	California	155,973	217.16	38	Y	
5	Illinois	12,419,293	24	Illinois	55,593	223.40	39	Y	
6	Pennsylvania	12,281,054	32	Pennsylvania	44,820	274.01	40	N	
7	Ohio	11,353,140	35	Ohio	40,953	277.22	41	N	
4	Florida	15,982,378	26	Florida	53,997	295.99	42	Y	
45	Delaware	783,600	49	Delaware	1,955	400.82	43	Y	
3	New York	18,976,457	30	New York	47,223	401.85	44		
19	Maryland	5,296,486	42	Maryland	9,775	541.84	45	Y	
29	Connecticut	3,405,565	48	Connecticut	4,845	702.90	46	Y	
13	Massachusetts	6,349,097	45	Massachusetts	7,838	810.04	47	Y	
43	Rhode Island	1,048,319	50	Rhode Island	1,045	1003.18	48	Y	
9	New Jersey	8,414,350	46	New Jersey	7,418	1134.32	49	Y	19
44	Montana	902,195	4	Montana	145,556	6198.27	50	Y	
50	Washington, D.C.	572,059	51	Washington, D.C.	61.4	9316.92	51	Y	
		*Source; Department of Commerce, Bureau of Census			**Source: Almanac - U.S.; Department of Commerce, Bureau of the Census			Based on Community Catalyst 1999 chart	

http://www.lpl.org/youth/stateknow/popchart.html

Certifcate of Need shown compared to Population and Size

17	Only for long term beds
18	Only for counties over 100,000 population
19	Only for acute care hospitals

Certificate of Need Chart

18-Nov-99

State	CON (Y/N)?	Oversight Agency	Change in ownership	Constructing a new hospital	Closing a hospital	Decreasing services	Decreasing # of beds	Merger or consolidation	Limits # of acquisitions	Considers community benefits and/or level of indigent care before issuance	Public access to application	Public notice of application	Public hearing on application	Public able to appeal decision
			Certificate is required for:											
Alabama	Y	State Health Planning and Development Agency		X			X				X	X	X	
Alaska	Y	Department of Health and Social Services		X			X[4]							X
Arizona	N													
Arkansas	Y	State Board of Health (Division of Health Facilities Services)		X										
California	Y	Office of Statewide Planning and Development		X								X	X	
Colorado	N													
Connecticut	Y	Office of Health Care Access	X			X	X					X	X	
District of Columbia	Y	State Health Planning and Development Agency	X		X	X	X[3]			X[2]	X		X[2]	X
Delaware	Y	Delaware Health Resources Board	X[8]	X							X	X	X	X
Florida	Y	Agency for Health Care Administration	X[2]	X								X	X[4]	
Georgia	Y	Department of Community Health		X								X		
Hawaii	Y	State Health Planning and Development Agency		X[1]		X	X						X	X
Idaho	N													
Illinois	Y	Health Facilities Planning Board	X	X	X	X	X				X	X	X	
Indiana	Y[8]	The State Department												
Iowa	Y	Department of Public Health and Facilities Council		X		X[7]	X[7]			X		X	X	X
Kansas	N													
Kentucky	Y	Cabinet for Human Resources	X[3]	X		X[9]	X[9]						X[4]	X[10]

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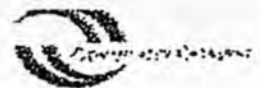
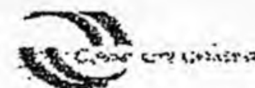


18-Nov-99

Certificate is required for:

State	CON (Y/N)?	Oversight Agency	Change in ownership	Constructing a new hospital	Closing a hospital	Overseeing services	Decreasing # of beds	Merger or consolidation	Limits # of acquisitions	Considers community benefits and/or level of indigent care before issuance	Public access to application	Public notice of application	Public hearing on application	Public able to appeal decision
Louisiana	Y	Department of Health and Hospitals		X										
Maine	Y	Department of Human Services and Certificate of Need Advisory Committee	X							X	X	X	X	X
Maryland	Y	State Health Resources Planning Commission	X	X	X	X	X					X	X	X
Massachusetts	Y	Department of Public Health	X	X		X	X				X		X	X
Michigan	Y	Department of Public Health and Certificate of Need Commission	X	X										
Minnesota	N													
Mississippi	Y	State Department of Health	X	X								X	X	
Missouri	Y	Missouri Health Facilities Review Committee				X	X					X	X	
Montana	Y	Department of Public Health and Human Services									X	X	X	
Nebraska	Y	Department of Health and Human Services Regulation and Licensure												
Nevada	Y[16]	Department of Human Resources		X[16]										
New Hampshire	Y	Health Services Planning and Review Board	X	X						X	X	X	X	X
New Jersey	Y	Department of Health and Senior Services	X[17]	X										
New Mexico	N													
New York[20]	Y	Department of Health		X									X	
North Carolina	Y	Department of Health and Human Services	X	X			X			X				



18-Nov-99														
			Certificate is required for:											
State	CON (Y/N)?	Oversight Agency	Change in ownership	Constructing a new hospital	Closing a hospital	Decreasing services	Decreasing # of beds	Merger or consolidation	Limits # of acquisitions	Considers community benefits and/or level of indigent care before issuance	Public access to application	Public notice of application	Public hearing on application	Public able to appeal decision
North Dakota	N													
Ohio	N													
Oklahoma	N													
Oregon	Y	Health Division of the Department of Human Resources		X										X
Pennsylvania	N													
Rhode Island	Y	Department of Health		X			X				X		X	X
South Carolina	Y	Department of Health and Environmental Control	X	X								X	X[2]	X
South Dakota	N													
Tennessee	Y	Health Facilities Commission		X		X						X	X	X
Texas	N													
Utah	N													
Vermont	Y	Health Policy Council	X	X			X			X		X	X	
Virginia	Y	Department of Health		X								X	X	
Washington	Y	Department of Health	X	X						X			X[2]	
West Virginia	Y	West Virginia Health Care Cost Review Authority	X	X	X	X	X			X	X	X	X[15]	X
Wisconsin	N													
Wyoming	N													
Total: 51	35		18	29	4	11	15	0	0	8	10	19	25	16
Percentage	69%		35%	57%	8%	22%	29%	0%	0%	16%	20%	37%	49%	31%

Notes are on the following page

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Notes

1. For any change
2. Hearing not required, must be requested
3. CoN not needed if gave prior notice
4. All applicants must certify that they will provide uncompensated care (charity care and bad debt) for the next five years at a percentage equal to or greater than the previous two years
5. Hearing only for purchase or lease of hospital
6. Only for acquisition of a nonprofit health care facility
7. Referred to as "certificate of exemption"
8. CoN only needed for Comprehensive Care Beds
9. But may be exempt
10. Any affected person may appeal the decision
11. But, only in the case of lease arrangements
12. For change in bed capacity or services
13. DPH may hold a hearing, or applicant, state, or 10 taxpayers may request a hearing
14. CoN not required, but must give notice
15. CoN not required for hospitals
16. Hearing not required, must be requested, or Authority may schedule on own initiative
17. As of June 12, 1997, a CoN in Nebraska is only required when creating, relocating, or converting long term care beds
18. CoN only required for counties with a population less than 100,000 and for projects costing more than $2 million
19. Only for acute care hospitals
20. New York does not have licenses or CoNs, it has "certificates" that encompass both licensing and CoN
21. CoN for long term care facilities such as nursing homes
22. Only for discontinuing obstetrical or maternity services

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HESS Committee Information: 4-4-02

You've heard some interesting comments from hospital industry people. Much of what they've told you is misquoted or wrong. I'd like to address several of these issues.

1. **Hospital Claim** - Doctors engage in "cherry-picking", don't see Medicare, Medicaid and "self-pay" patients. **Truth**: At Tanana Valley Clinic, 24% of our patients are Medicare or Medicaid and 9% have no insurance at all. That means 30,000 Medicare and Medicaid patients each year and 11,000 patients annually without any insurance. We provided $6.9 million worth of charity care to Medicare and Medicaid patients last year, and $2.6 million care to patients with no insurance: these are the patients that the hospitals say we refuse to see. In addition, over the past 3 years, TVC provided nearly $18 million in charity care. The hospitals want you to think that they are the only ones who provide charity care but the fact is that we provide nearly six million dollars each year. Also, the hospital's argument can easily be turned on its head. We aren't exempt from taxes as the hospitals are, so we can't continue to provide millions in charity care if we don't expand our community services, and if the hospitals are allowed to keep "cherry-picking" the patients with the best insurance.

2. **Hospital Claim:** patients suffer higher mortality rates in non-CON states. **Truth**: Fairbanks Memorial quoted a Florida study that covered only *cardiac surgery*, but the hospitals misapply this information and try to trick you into thinking that quality of care is lower in non-CON states. This is completely incorrect and is directly contradicted by a study of 1,000 hospitals, quoted in the "Journal of Health Politics, Policy and Law" in 1998 that clearly says *"...that states with more stringent CON policies or hospital rate-setting experienced higher mortality rates."(page 477 in Conover)*. A 1999 Washington state study of CON states "*The evidence is weak regarding the ability of CON to improve quality by concentrating volume of specialized services*". (*"Effects of CON and its Possible Repeal*" page iii). In addition, a Northwestern University study of more that 200,000 patients in 45 states concluded that states with the most stringent CON

regulations had mortality rates 5 to 6 percent higher than states with less stringent CON regulations. (*Goodman and Musgrave, "Patient Power", 1992*) If anything, CON doesn't improve quality of care - it raises patient mortality rates.

3. **Hospital Claim**: If the CON law is modified, "This could very likely lead to catastrophic increases in costs Statewide, and perhaps even the closure of some of Alaska's most vulnerable rural hospitals" (March Fairbanks Memorial letter to legislators) **Truth**: In a 1993 article titled "Certificate of Need Revisited", health care expert Daniel Mendelson said "*Legislators also are frequently interested in whether costs increased in states that repealed CON. We have found no evidence of increased costs in the 12 states that repealed their CON programs*". Then in 1998, Professor Conover made the following point about the 15 states that by then had then eliminated CON: "*States that lifted CON did not experience a rise in spending on hospital and physician services relative to those that retained it.*" (Conover, page 478). A third 1999 study (*Effects of CON and It's Possible Repeal, page 13*) noted that the financial effects of eliminating CON "*....have been insufficiently studied to determine if there are any persistent effects on cost*". Clearly the Hospitals scare tactics are absolutely wrong, as documented in three recent professional studies. In fact it's just the opposite - Conover quotes a 1991 study on health care costs, stating "*...CON was associated with a 20.6% increase in hospital spending and a nine percent increase in other health care.*"

4. **Hospital Claim**: Eliminating CON will have such a severe impact on them that they will eliminate some of the less profitable services that they now provide – charity care will be eliminated (March Fairbanks Memorial letter to legislators). **Truth**: Conover's 1998 study said CON is linked to "*....increased hospital profitability...*" and "*...lifting CON had no impact on any of these dependent variables*". In other words, Conover shows that removing CON has no impact on hospital profitability, and will not lead to any decrease in charity care. The 1999 Washington study referenced above also notes "*...we found no studies that directly link CON with higher levels of charity care*" (*Effects of CON and Its Possible Repeal, page 23*). Clearly there is no evidence that eliminating CON

reduces charity care – this is another example of hospital scare-mongering that is contradicted by independent scientific research.

Final Note: Doctors throughout the country are being forced to limit or exclude the numbers of Medicare or Medicaid patients they see, because of the extraordinary low payments they receive for these patients – 27% for Medicare and 55% for Medicaid at TVC. In Seattle, hundreds of doctors have begun to close their practices to Medicare and Medicaid and many doctors are leaving the area (see Seattle PI article in 4/1/02 edition). At TVC, with our total 33% Medicare, Medicaid and "no-insurance" patients, we have been taking a terrible financial beating in recent years – doctors pay is down over 20% since last year. We have lost 11 doctors out of 26 in less than two years, in large part because they cannot pay their bills if they see 1/3 Medicare, Medicaid and "no-insurance" patients. We cannot continue to see anyone who presents themselves at our doors, as is our current policy, if we cannot cover our costs. Thus, if the CON law continues to guarantee the hospitals a monopoly over such services as ambulatory surgery, the 40,000 Medicare, Medicaid and "no insurance" patients TVC sees annually may be forced to go to the hospital for care and will become the responsibility of the community and the State. We do not want to see this happen, but you need to realize that the doctors of our community can not continue to carry this multi-million dollar charity care burden, while hospitals cut back their services to the poor and escape payment of any taxes in our community. TVC pays more property taxes than any other locally owned business in the Borough - the hospital pays none. We pay State corporate taxes – the hospital pays none. We will do our share, but our position is becoming tenuous.

Thank you. I'd be happy to answer any questions.

Brian Slocum
Administrator
Tanana Valley Clinic
(907) 459 - 3509

22-LS1389\O
Lauterbach
4/4/02

CS FOR HOUSE BILL NO. 407( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES COGHILL, James, Scalzi, Dyson

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the certificate of need program; and providing for an effective**
2 **date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** AS 18.07.031(a) is repealed and reenacted to read:
5 (a) Except as provided in (c) of this section, a person may not, unless
6 authorized under the terms of a certificate of need issued by the department, make an
7 expenditure of
8 (1) any amount for
9 (A) construction of a skilled nursing facility or psychiatric
10 hospital;
11 (B) an increase in the bed capacity of a skilled nursing facility
12 or psychiatric hospital;
13 (C) conversion of a building or part of a building to a skilled
14 nursing facility or psychiatric hospital;

1 (D) conversion of a bed in a health care facility to a psychiatric
2 bed designated for care of a child under 21 years of age;
3 (E) conversion of the existing use of a bed in a health care
4 facility to a new bed use other than new use as a psychiatric bed designated for
5 the care of a child under 21 years of age if the existing use required a
6 certificate of need at the time the use was established and the health care
7 facility is located in the unorganized borough or in an organized borough with
8 a population of less than 55,000 at the time of the proposed conversion,
9 according to the latest reliable data approved by the Department of Community
10 and Economic Development; or
11 (2) $1,000,000 or more for
12 (A) addition of a category of health services provided by a
13 skilled nursing facility or a psychiatric hospital; or
14 (B) construction of a health care facility other than a skilled
15 nursing facility or psychiatric hospital, alteration of the bed capacity of a health
16 care facility other than a skilled nursing facility or psychiatric hospital, or
17 addition of a category of health services provided by a health care facility other
18 than a skilled nursing facility or psychiatric hospital, if the health care facility
19 is located in the unorganized borough or in an organized borough with a
20 population of less than 55,000 at the time of commencement of activities,
21 according to the latest reliable data approved by the Department of Community
22 and Economic Development.
23 * **Sec. 2.** AS 18.07.031(c) is amended to read:
24 (c) Notwithstanding (a) of this section, a person who is lawfully **authorized to**
25 **operate** [OPERATING] a health care facility [THAT IS AN AMBULATORY
26 SURGICAL FACILITY] at a site may make an expenditure of any amount in order to
27 **replace the facility at the same site or** relocate the services of that facility to a new
28 site in the same community without obtaining a certificate of need as long as neither
29 the bed capacity nor the number of categories of health services provided at the new
30 site **or in the new facility** is greater**, the percentage of beds designated for each**
31 **type of use at the new site or in the new facility is not different from the**

1 percentage of beds designated for that type of use at the old site or in the previous
2 facility, and no new category of health services is provided at the new site or in
3 the new facility. However, [NOTWITHSTANDING THE EXPENDITURE
4 THRESHOLD IN (a) OF THIS SECTION,] a person may not use the site from which
5 the health care facility relocated for another health care facility unless the person
6 complies with the [AUTHORIZED UNDER A] certificate of need requirements of
7 (a) of this section [ISSUED BY THE DEPARTMENT].

8 * **Sec. 3.** AS 18.07.035 is amended to read:

9 **Sec. 18.07.035. Application and fees.** Application for a certificate of need
10 shall be made to the department upon a form provided by the department and must
11 contain the information the department requires to reach a decision about whether to
12 issue the certificate of need [UNDER THIS CHAPTER]. Each application for a
13 certificate of need must be accompanied by an application fee established by the
14 department by regulation. **The department shall, by regulation, set a time limit by**
15 **which the department shall determine whether an application submitted under**
16 **this section is complete and contains all of the information the department**
17 **requires to reach a decision about whether to issue the certificate of need.**

18 * **Sec. 4.** AS 18.07 is amended by adding new sections to read:

19 **Sec. 18.07.037. Public hearing required.** Except as provided in
20 AS 18.07.071, the department shall hold a public hearing within a reasonable time
21 after determining that an application under AS 18.07.035 is complete. By regulation,
22 the department shall establish

23 (1) a time limit by which a public hearing required under this section
24 shall be held; and

25 (2) procedures for conducting a public hearing held under this section.

26 **Sec. 18.07.039. Time limit for decision on application.** Based on the
27 standards for review under this chapter, the department shall, within 120 days after
28 determining that an application under AS 18.07.035 is complete, approve or deny the
29 application.

30 * **Sec. 5.** AS 18.07.043 is amended to read:

31 **Sec. 18.07.043. Standard of review for applications for certificates of need**

1 **and applications to modify certificates of need** [RELATING TO NURSING
2 HOMES AND NURSING HOME BEDS]. (a) The department shall develop
3 review standards for an application for a certificate of need, or for a modification of a
4 certificate of need, issued under this chapter [FOR A HEALTH CARE FACILITY
5 THAT IS A NURSING HOME OR HAS NURSING HOME BEDS].
6 (b) **When determining whether to approve an application for a new**
7 **certificate of need or to modify an existing certificate of need** [IN DEVELOPING
8 THE REVIEW STANDARDS UNDER (a) OF THIS SECTION], the department
9 shall consider whether
10 (1) a public process and existing appropriate statewide, regional, and
11 local plans were included in planning and designing the **project** [ADDITIONAL
12 NURSING HOME BEDS OR THE HEALTH CARE FACILITY];
13 (2) the **project will meet** [ADDITIONAL NURSING HOME BEDS
14 OR THE HEALTH CARE FACILITY MEETS] minimum required use rates for **the**
15 **proposed services without causing the** [NEW NURSING BEDS, AND THE
16 EFFECT ON] use rates for existing **providers of the services to fall below minimum**
17 **required use rates** [NURSING HOME BEDS];
18 (3) the **project** [ADDITIONAL NURSING HOME BEDS OR THE
19 HEALTH CARE FACILITY] demonstrates consideration of the community, regional,
20 and statewide needs [FOR NEW NURSING HOME BEDS];
21 (4) the **project** [ADDITIONAL NURSING HOME BEDS OR THE
22 HEALTH CARE FACILITY] meets the minimum **standards of the department that**
23 **are designed** [NUMBER OF NEW NURSING BEDS THAT SHOULD BE
24 REQUIRED IN A FACILITY] to ensure efficiency and economies of scale;
25 (5) the **project** [ADDITIONAL NURSING HOME BEDS OR THE
26 HEALTH CARE FACILITY] demonstrates the proposed service will provide a
27 quality of care equivalent to existing community, regional, or statewide services;
28 (6) the **project** [ADDITIONAL NURSING HOME BEDS OR THE
29 HEALTH CARE FACILITY] demonstrates financial feasibility, including long-term
30 viability, and what the financial effect will be on consumers and the state; and
31 (7) the sponsor has demonstrated cost effectiveness through

1 considering the availability of appropriate, less costly alternatives of providing the
2 services planned.
3 (c) The department shall grant a sponsor a certificate of need or modify a
4 certificate of need [THAT AUTHORIZES NURSING HOME BEDS OR THAT IS
5 FOR A HEALTH CARE FACILITY THAT IS A NURSING HOME] if the
6 department finds that the sponsor meets the standards established in or under this
7 chapter.
8 * **Sec. 6.** AS 18.07.071(b) is amended to read:
9 (b) The department may grant a sponsor a temporary certificate for the
10 temporary operation of a category of health service if the sponsor shows by affidavit
11 or formal hearing
12 (1) the necessity for early, immediate, or temporary relief; and
13 (2) adverse effect to the public interest by reason of delay occasioned
14 by compliance with the requirements of **AS 18.07.043** [AS 18.07.041, 18.07.043,] and
15 application procedures prescribed by regulations under this chapter.
16 * **Sec. 7.** AS 18.07.071(c) is amended to read:
17 (c) A temporary certificate granted under (b) of this section does not confer
18 vested rights on behalf of the applicant. The department shall impose those special
19 limitations and restrictions concerning duration and right of extension that the
20 department considers appropriate. A temporary certificate may not be granted for a
21 period longer than necessary for the sponsor to obtain review of the action certified by
22 the temporary certificate under AS 18.07.051. Application for a certificate of need
23 **that will be reviewed** under **AS 18.07.043** [AS 18.07.041 OR 18.07.043] must
24 commence within 60 days **after** [OF] the date of issuance of the temporary certificate.
25 * **Sec. 8.** AS 18.07.081(c) is amended to read:
26 (c) A certificate of need shall be suspended if an accusation is filed before the
27 commencement of activities authorized under **AS 18.07.043** [AS 18.07.041 OR
28 18.07.043] that charges that factors upon which the certificate of need was issued have
29 changed or new factors have been discovered that significantly alter the need for the
30 activity authorized. A suspension of a certificate may not exceed 60 days. At the end
31 of this period or sooner, the department shall revoke or reinstate the certificate.

1 * **Sec. 9.** AS 18.07.081(d) is amended to read:
2 (d) A certificate of need may be revoked if
3 (1) the sponsor has not shown continuing progress toward
4 commencement of the activities authorized under **AS 18.07.043 within** [AS 18.07.041
5 OR 18.07.043 AFTER] six months **after the date** of issuance **of the certificate;**
6 (2) the applicant fails, without good cause, to complete activities
7 authorized by the certificate;
8 (3) the sponsor fails to comply with [THE PROVISIONS OF] this
9 chapter or regulations adopted under this chapter;
10 (4) the sponsor knowingly misrepresents a material fact in obtaining
11 the certificate;
12 (5) the facts charged in an accusation filed under (c) of this section are
13 established; or
14 (6) the sponsor fails to provide services authorized by the terms of the
15 certificate.
16 * **Sec. 10.** AS 18.07.111(2) is amended to read:
17 (2) "certificate" means a certificate of need issued by the department
18 under **AS 18.07.043 or 18.07.071** [AS 18.07.041, 18.07.043, OR 18.07.071];
19 * **Sec. 11.** AS 18.07.031(b) and 18.07.041 are repealed.
20 * **Sec. 12.** The uncodified law of the State of Alaska is amended by adding a new section to
21 read:
22 APPLICABILITY. AS 18.07, as amended by secs. 1 - 11 of this Act, applies to
23 applications for certificates of need that are initially filed on or after the effective date of this
24 Act.
25 * **Sec. 13.** This Act takes effect immediately under AS 01.10.070(c).

Please enter into the record my testimony to the H.E.S.S.
Committee Name

Committee on House Bill 407 Dated 4/03/2002
Bill / Subject

Thank You for accepting my testimony, I was here on Tuesday but was unable to return for the April 4th hearing. My name is Anne Lilley. I have been a nurse practitioner in Alaska for the last 7 years and a nurse in Alaska for the last 22 years. I was recently hired as Manager of Clinical Education for Fairbanks Memorial Hospital, and I have a concern for the hospital. I am also concerned about the provision of mental health and recovery services in Fairbanks, having worked extensively with members of this underserved population in Interior Alaska for the last several years.

I oppose House Bill 407 and agree with previous testimony that supports continuing the Certificate of Need program (CON). I see this as basically an issue of health care planning. Do we plan health care and include public comment and oversight as we do with other essential services such as roads and disaster services or do we let the free market decide which needs are met?

My understanding of the intent of HB407 is to decrease health care costs by encouraging competition and cutting down on red tape. I support the concept but I don't feel it translates well into the health care arena, especially in Alaska. Further, I am troubled by the many comparisons of health care to other free market commodities. One of the ways health care is different is in the way services are provided:
If, as a provider, I order an MRI at a local hospital, my patient will almost always go the hospital for an MRI. If I order an MRI at a local clinic that I am affiliated with the patient will rarely request that the MRI be done in another location. The physician or other ordering provider really directs the selection of the facility, not the patient.

Neither is the ordering provider always free to order a procedure at any facility he or she chooses. Issues of credentialing or privileges, contracts and/or group ownership often control provider selection of services. In this instance and many others, free market comparisons don't fit.

The other issue is that some areas of health care are simply not profitable. Mental health and addiction services come to mind. Lack of adequate services for these conditions already places an incredible financial burden on the state. What happens to these services if the free market model is applied to health care? . The potential is there for this bill to work in direct opposition to it's intended effect.

I would simply like to know that SOMEONE is asking how health care development will affect patient outcomes in any given Alaskan community in 5 or 10 or 15 years. I believe we need a STRONG public health planning process in order to control long-term health care costs in Alaska. CON provides the teeth for that planning process to be effective, if the process needs to be improved, let's improve it without weakening the purpose of CON.

SIGNED: Anne M. Lilley
Testifier

Anne M. Lilley, RN, MSN, FNP
Fairbanks Memorial Hospital
Representing

P.O. BOX 82868, Fairbanks, AK 99708 Phone Wk: 458 - 5189
Address / Phone Number 388 - 8783

Subject: HB407
Date: Mon, 8 Apr 2002 09:28:24 -0800
From: "Lewis, Steve" <STLewis@PetroStar.com>
To: "'Representative_Fred_Dyson@legis.state.ak.us'" <Representative_Fred_Dyson@legis.state.ak.u:
"'Representative_Peggy_Wilson@legis.state.ak.us'" <Representative_Peggy_Wilson@legis.state.
"'Representative_John_Coghill@legis.state.ak.us'" <Representative_John_Coghill@legis.state.ak
"'Representative_Vic_Kohring@legis.state.ak.us'" <Representative_Vic_Kohring@legis.state.ak.
"'Representative_Gary_Stevens@legis.state.ak.us'" <Representative_Gary_Stevens@legis.state.a
"'Representative_Sharon_Cissna@legis.state.ak.us'" <Representative_Sharon_Cissna@legis.state
"'Representative_Reggie_Joule@legis.state.ak.us'" <Representative_Reggie_Joule@legis.state.ak

Dear Representatives,

It is my understanding that HB-407 will be coming up for a vote in the House HESS committee early next week and I would urge each of you to vote in favor of HB 407 and move it out of your committee, as it is currently drafted, to the Rules Committee. Petro Star Inc.and our subsidiaries Sourdough fuel and Petroleum Sales, along with our Sister companies Natchiq, APC and Houston Contracting CO. employ more than 800 employees in the Fairbanks area. Not only do we have that many employees, but for the most part each of them represents a house hold that we provide medical benefits to. After living in Fairbanks for more than 24 years of my career, before moving to Anchorage, I certainly recognize the politics involved in this issue and the special interest that are represented on both sides. However, not only does this bill provide an avenue for competition, which is always good from the stand point of cost, but it also gives the citizens of the North Star Borough greater choices relative to their medical care, both from a dollar standpoint and availability of services. Not only is the current system potentially costly to our company, it limits the choices of our employees. Competition is good for the community and lack of it can only produce higher cost and less services. Again I would urge you to vote in favor of HB-407.

Sincerely,

Stephen T. Lewis
Chairman and CEO
Petro Star Inc.

JASON - Put THIS IN my Packet ON HB 407

ALSO GIVE to Committee Members

FAIRBANKS LEGISLATIVE INORMATION OFFICE
119 N. CUSHMAN ST. SUITE 101
FAIRBANKS, AK 99701

WRITTEN TESTIMONY TRANSMITTAL SHEET

TO: House HESS Committee	FROM: Fran/Fbx LIO
COMPANY:	DATE: 4/2/2002
FAX NUMBER: 465-4587	
PHONE NUMBER: 465-3759	FAXED ON: 04/02/2002
RE: Written Testimony: HB 407	TELECONFERENCED ON: 04-02-02

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:
Enclosed please find written testimony for HHES teleconference on 04-02-02.

PHONE: 452-4448
FAX: 456-3346

HB407 Testimony

Carl Wales

2 April 2002

Statistics used

- The statistics used in this testimony are shown in accompanying material. The source of that information is shown in the material.

Certificate of Need (CON) Process

- While I have not found a written history which I can quote to support this, it is my understanding that the CON process evolved initially as a requirement of the federal government in hopes that it would control health care costs.

- Many states have realized that it does not serve that purpose so that now 30 % of the states have no CON.

CON Requirements

- Of the ten **least** densely populated states only two have a CON requirement. Of those two, one requires a CON only for counties with a population of over 100,000 and the other requires a CON only for long term care beds.
- Of the top 15 least densely populated states only four require the CON (the two above plus two more).

- Residents of states with high population densities have options/choices by virtue of having lots of facilities.
- This provides choice and drives efficiency in delivering health care.

- States with small populations need a "free market system" to foster choices and competition.

- Why is Alaska the only one in the top seven least densely populated states with a CON requirement?

Myth

- "Non-profit" and "Not-for-profit" do not necessarily mean efficient operation of the organization.
- Many "Non-profit" and "Not-for-profit" organizations that are funded through charities are driven to greater efficiency because the donors may donate to other causes (donors have choices).
- Health care organizations (and other types of organizations) that have a monopoly are not driven to be efficient and provide the highest quality– they can exist, and continue to exist, and be inefficient, by virtue of their being the *only* choice no matter how bad the choice is.

Carl Wales

- Resident of Fairbanks since 1993.
- I do not work for any part of the health care system.
- I do not own stock in or benefit in any way from the health care industry beyond being a patient.

Accompanying material

- Spreadsheet showing state sizes and populations plus the calculations to determine population density and ranking.
- Chart of states requiring the CON taken from the Community Catalyst web site.

Certifcate of Need shown compared to Population and Size

Rank by Population	State	Population (2000 est.*)	Rank by Size	State	Size (Sq. miles of land**)	Pop Density	Rank by Density	CON	
48	Alaska	626,932	1	Alaska	570,374	1.10	1	Y	
51	Wyoming	493,782	9	Wyoming	97,105	5.09	2	N	
47	North Dakota	642,200	17	North Dakota	68,994	9.31	3	N	
46	South Dakota	754,844	16	South Dakota	77,122	9.79	4	N	
36	New Mexico	1,819,046	5	New Mexico	121,365	14.99	5	N	
39	Idaho	1,293,953	11	Idaho	82,751	15.64	6	N	
35	Nevada	1,998,257	7	Nevada	109,806	18.20	7	Y	18
38	Nebraska	1,711,263	15	Nebraska	75,898	22.55	8	Y	17
34	Utah	2,233,169	12	Utah	82,168	27.18	9	N	
32	Kansas	2,688,418	13	Kansas	81,823	32.86	10	N	
28	Oregon	3,421,399	10	Oregon	96,003	35.64	11	Y	
40	Maine	1,274,923	39	Maine	30,865	41.31	12	Y	
24	Colorado	4,301,261	8	Colorado	103,729	41.47	13	N	
20	Arizona	5,130,632	6	Arizona	113,642	45.15	14	N	
27	Oklahoma	3,450,654	19	Oklahoma	68,679	50.24	15	N	
33	Arkansas	2,673,400	27	Arkansas	52,075	51.34	16	Y	
30	Iowa	2,926,324	23	Iowa	55,875	52.37	17	Y	
31	Mississippi	2,844,658	31	Mississippi	46,914	60.64	18	Y	
21	Minnesota	4,919,479	14	Minnesota	79,617	61.79	19	N	
49	Vermont	608,827	43	Vermont	9,249	65.83	20	Y	
37	West Virginia	1,808,344	41	West Virginia	24,087	75.08	21	Y	
2	Texas	20,851,820	2	Texas	261,914	79.61	22	N	
17	Missouri	5,595,211	18	Missouri	68,898	81.21	23	Y	
23	Alabama	4,447,100	28	Alabama	50,750	87.63	24	Y	
15	Washington	5,894,121	20	Washington	66,582	88.52	25	Y	
18	Wisconsin	5,363,675	25	Wisconsin	54,314	98.75	26	N	
25	Kentucky	4,041,769	36	Kentucky	39,732	101.73	27	Y	
22	Louisiana	4,468,976	33	Louisiana	43,566	102.58	28	Y	

Certifcate of Need shown compared to Population and Size

26	South Carolina	4,012,012	40	South Carolina	30,111	133.24	29	Y	
41	New Hampshire	1,235,786	44	New Hampshire	8,969	137.78	30	Y	
16	Tennessee	5,689,283	34	Tennessee	41,220	138.02	31	Y	
10	Georgia	8,186,453	21	Georgia	57,918	141.35	32	Y	
11	North Carolina	8,049,313	29	North Carolina	48,718	165.22	33	Y	
14	Indiana	6,080,485	38	Indiana	35,870	169.51	34	Y	
8	Michigan	9,938,444	22	Michigan	56,809	174.94	35	Y	
12	Virginia	7,078,515	37	Virginia	39,598	178.76	36	Y	
42	Hawaii	1,211,537	47	Hawaii	6,423	188.62	37	Y	
1	California	33,871,648	3	California	155,973	217.16	38	Y	
5	Illinois	12,419,293	24	Illinois	55,593	223.40	39	Y	
6	Pennsylvania	12,281,054	32	Pennsylvania	44,820	274.01	40	N	
7	Ohio	11,353,140	35	Ohio	40,953	277.22	41	N	
4	Florida	15,982,378	26	Florida	53,997	295.99	42	Y	
45	Delaware	783,600	49	Delaware	1,955	400.82	43	Y	
3	New York	18,976,457	30	New York	47,223	401.85	44	Y	
19	Maryland	5,296,486	42	Maryland	9,775	541.84	45	Y	
29	Connecticut	3,405,565	48	Connecticut	4,845	702.90	46	Y	
13	Massachusetts	6,349,097	45	Massachusetts	7,838	810.04	47	Y	
43	Rhode Island	1,048,319	50	Rhode Island	1,045	1003.18	48	Y	
9	New Jersey	8,414,350	46	New Jersey	7,418	1134.32	49	Y	19
44	Montana	902,195	4	Montana	145.556	6198.27	50	Y	
50	Washington, D. C.	572,059	51	Washington, D.C.	61.4	9316.92	51	Y	
		*Source; Department of Commerce, Bureau of Census			**Source: Almanac - U.S.; Department of Commerce, Bureau of the Census			Based on Community Catalyst 1999 chart	

http://www.ipl.org/youth/stateknow/popchart.html

Certifcate of Need shown compared to Population and Size

17	Only for long term beds
18	Only for counties over 100,000 population
19	Only for acute care hospitals

Certificate of Need Chart

18-Nov-99

Certificate is required for:

State	CON (Y/N)?	Oversight Agency	Change in ownership	Constructing a new hospital	Closing a hospital	Decreasing services	Decreasing # of beds	Merger or consolidation	Limits # of acquisitions	Considers community benefits and/or level of indigent care before issuance	Public access to application	Public notice of application	Public hearing on application	Public able to appeal decision
Alabama	Y	State Health Planning and Development Agency		X			X[1]				X	X	X	
Alaska	Y	Department of Health and Social Services		X			X[1]							X
Arizona	N													
Arkansas	Y	State Board of Health (Division of Health Facilities Services)		X										
California	Y	Office of Statewide Planning and Development		X								X	X[2]	
Colorado	N													
Connecticut	Y	Office of Health Care Access	X			X	X					X	X	
District of Columbia	Y	State Health Planning and Development Agency	X		X	X	X[3]			X[4]	X		X[5]	X
Delaware	Y	Delaware Health Resources Board	X[6]	X							X	X	X[2]	X
Florida	Y	Agency for Health Care Administration	X[3]	X								X	X[2]	
Georgia	Y	Department of Community Health		X								X		
Hawaii	Y	State Health Planning and Development Agency		X[1]		X	X						X	X
Idaho	N													
Illinois	Y[7]	Health Facilities Planning Board	X	X	X	X	X				X	X	X	
Indiana	Y[8]	The State Department												
Iowa	Y	Department of Public Health and Facilities Council		X		X[9]	X[9]			X		X	X	X
Kansas	N													
Kentucky	Y	Cabinet for Human Resources	X[9]	X		X[9,1]	X[9,1]						X[2]	X[10]

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COMMUNITY CATALYST

18-Nov-99															
			Certificate is required for:												
State	CON (Y/N)?	Oversight Agency	Change in ownership	Constructing a new hospital	Closing a hospital	Decreasing services	Decreasing # of beds	Merger or consolidation	Limits # of acquisitions	Considers community benefits and/or level of indigent care before issuance	Public access to application	Public notice of application	Public hearing on application	Public able to appeal decision
Louisiana	Y	Department of Health and Hospitals		X										
Maine	Y	Department of Human Services and Certificate of Need Advisory Committee	X[11]							X	X	X	X	X
Maryland	Y	State Health Resources Planning Commission	X[3]	X	X[3]	X[9,1]	X[9,1]					X[12]	X[2]	X
Massachusetts	Y	Department of Public Health	X	X		X[1]	X[1]				X		X[13]	X
Michigan	Y	Department of Public Health and Certificate of Need Commission	X	X										
Minnesota	N													
Mississippi	Y	State Department of Health	X[3]	X								X	X[2]	
Missouri	Y	Missouri Health Facilities Review Committee				X[14]	X[14]					X	X[2]	
Montana	Y[15]	Department of Public Health and Human Services									X	X	X[16]	
Nebraska	Y[17]	Department of Health and Human Services Regulation and Licensure												
Nevada	Y[18]	Department of Human Resources		X[18]										
New Hampshire	Y	Health Services Planning and Review Board	X	X						X	X	X	X	X
New Jersey	Y	Department of Health and Senior Services	X[19]	X										
New Mexico	N													
New York[20]	Y	Department of Health		X									X[16]	
North Carolina	Y	Department of Health and Human Services	X[3]	X			X[1]			X				

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18-Nov-99														
			Certificate is required for:											
State	**CON (Y/N)?**	**Oversight Agency**	**Change in ownership**	**Constructing a new hospital**	**Closing a hospital**	**Decreasing services**	**Decreasing # of beds**	**Merger or consolidation**	**Limits # of acquisitions**	**Considers community benefits and/or level of indigent care before issuance**	**Public access to application**	**Public notice of application**	**Public hearing on application**	**Public able to appeal decision**
North Dakota	N													
Ohio	N													
Oklahoma	N[21]													
Oregon	Y	Health Division of the Department of Human Resources		X										X
Pennsylvania	N													
Rhode Island	Y	Department of Health		X			X[1]				X		X	X
South Carolina	Y	Department of Health and Environmental Control	X	X								X	X[2]	X
South Dakota	N													
Tennessee	Y	Health Facilities Commission		X		X[22]						X	X[2]	X
Texas	N													
Utah	N													
Vermont	Y	Health Policy Council	X	X			X[1]			X		X	X[2]	
Virginia	Y	Department of Health		X								X	X	
Washington	Y	Department of Health	X	X						X			X[2]	
West Virginia	Y	West Virginia Health Care Cost Review Authority	X	X	X	X	X			X	X	X	X[16]	X
Wisconsin	N													
Wyoming	N													
Total: 51	35		18	29	4	11	15	0	0	8	10	19	25	16
Percentage	69%		35%	57%	8%	22%	29%	0%	0%	16%	20%	37%	49%	31%

Notes are on the following page

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Notes

1. For any change
2. Hearing not required, must be requested
3. CoN not needed if gave prior notice
4. All applicants must certify that they will provide uncompensated care (charity care and bad debt) for the next five years at a percentage equal to or greater than the previous two years
5. Hearing only for purchase or lease of hospital
6. Only for acquisition of a nonprofit health care facility
7. Referred to as "certificate of exemption"
8. CoN only needed for Comprehensive Care Beds
9. But may be exempt
10. Any affected person may appeal the decision
11. But, only in the case of lease arrangements
12. For change in bed capacity or services
13. DPH may hold a hearing, or applicant, state, or 10 taxpayers may request a hearing
14. CoN not required, but must give notice
15. CoN not required for hospitals
16. Hearing not required, must be requested, or Authority may schedule on own initiative
17. As of June 12, 1997, a CoN in Nebraska is only required when creating, relocating, or converting long term care beds
18. CoN only required for counties with a population less than 100,000 and for projects costing more than $2 million
19. Only for acute care hospitals
20. New York does not have licenses or CoNs, it has "certificates" that encompass both licensing and CoN
21. CoN for long term care facilities such as nursing homes
22. Only for discontinuing obstetrical or maternity services

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PETRO STAR INC.

201 Arctic Slope Avenue, Suite 200
Anchorage, AK 99518-3030

PHONE: 907.344.2661 **FAX: 907.267.6124**

FAX TRANSMITTAL

Total Pages: (1)

DATE: April 8, 2002

TO:		
	Representative Fred Dyson	465-4587
	Representative Peggy Wilson	465-3175
	Representative John Coghill	465-3258
	Representative Vic Kohring	465-3808
	Representative Gary Stevens	465-3517
	Representative Sharon Cissna	465-4588
	Representative Reggie Joule	465-4586

MESSAGE: Dear Representatives:

It is my understanding that HB-407 will be coming up for a vote in the House HESS committee early next week and I would urge each of you to vote in favor of HB 407 and move it out of your committee, as it is currently drafted, to the Rules Committee. Petro Star Inc. and our subsidiaries Sourdough fuel and Petroleum Sales, along with our Sister companies Natchiq, APC and Houston Contracting CO. employ more than 800 employees in the Fairbanks area. Not only do we have that many employees, but for the most part each of them represents a house hold that we provide medical benefits to. After living in Fairbanks for more than 24 years of my career, before moving to Anchorage, I certainly recognize the politics involved in this issue and the special interest that are represented on both sides. However, not only does this bill provide an avenue for competition, which is always good from the stand point of cost, but it also gives the citizens of the North Star Borough greater choices relative to their medical care, both from a dollar standpoint and availability of services. Not only is the current system potentially costly to our company, it limits the choices of our employees. Competition is good for the community and lack of it can only produce higher cost and less services. Again I would urge you to vote in favor of HB-407.

Sincerely,

Stephen T. Lewis
Chairman and CEO
Petro Star Inc.

* * * * *

4.2.02

AMENDMENT

OFFERED IN THE HOUSE **BY REPRESENTATIVE CISSNA**

TO: HB 407

Add new section under temporary law:

The State of Alaska Department of Health and Social Services shall develop a comprehensive health plan for the state, making use of, to the maximum extent, existing health care plans and processes employed by the Department of Health and Social Services, other state agencies and local community efforts. A focus of the plan shall be to develop community-specific health information to assist the Certificate of need program in evaluating applications for certificates of need. A report will be submitted to the legislature by January 1, 2003.

passed 4.3

FISCAL NOTE

DRAFT

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS HB 407 (HES)
( ) Publish Date:

Revision Date/Time (Note if correction):
Title: RELATING TO CERTIFICATES OF NEED

Dept. Affected: Health & Social Services
BRU: Medical Assistance
Component: Medicaid Services

Sponsor: COGHILL
Requestor: HOUSE (HES)

Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	4,666.8	9,495.2	10,907.0	11,593.3	12,157.0	12,643.3
Miscellaneous						
TOTAL OPERATING	4,666.8	9,495.2	10,907.0	11,593.3	12,157.0	12,643.3
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
1002 Federal Receipts	2,719.3	5,532.8	6,355.5	6,755.4	7,083.9	7,367.2
1003 GF Match	1,947.5	3,962.4	4,551.5	4,837.9	5,073.1	5,276.1
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Othe (Specify Type--do not abbrevia						
TOTAL	4,666.8	9,495.2	10,907.0	11,593.3	12,157.0	12,643.3

Estimate of any current year (FY2002) cost:

Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal: [ ]

POSITIONS

POSITIONS						
Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill would require a CON for 1) the construction of, increase in bed capacity of, or conversion of a facility to a nursing facility or psychiatric hospital; 2) conversion of the bed use of a facility in the unorganized borough or community with a population of less than 55,000 if the existing facility required a CON; and 3) expenditure of $1 million or more for the addition of a category of services provided by a nursing facility or psychiatric hospital, or the construction alteration of or addition of a category of health services other than a nursing facility or psychiatric hospital in the unorganized borough or a community with a population under 55,000. This bill would allow a facility to relocate or be replaced at another site at any cost without a CON.

The purpose of the CON is to act as a deterrent to overbuilding health care facility capacity.

Prepared by: Nancy Weller — Phone 465-3355
Division: Medical Assistance — Date/Time 04/04/2002

Approved by: Elmer A. Lindstrom, Deputy Commissioner — Date 04/08/2002
Agency: Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

(Rev 2/7/2001 OMB)

DRAFT

FISCAL NOTE #

STATE OF ALASKA
2002 LEGISLATIVE SESSION

BILL NO. CS HB 407 (HES)

ANALYSIS CONTINUATION

Changes to the current CON requirement may have a cost impact on the Medicaid Program if a facility is allowed to be replaced before it's useful life is completely depreciated or if construction of excess bed capacity occurs. The last change to the CON law was in 1983, when the CON limit was increased from $150.0 to $1 million.

Certificate of Need staff in the Division of Administrative Services, DHSS, estimate that a number of facilities that have expressed an interest in construction will proceed if the proposed language is adopted. The construction of these facilities is expected to increase costs to the Medicaid budget as shown - no facility costs are included other than those known pending projects.

Assumptions in creating these projections include: use of the FFY 03 federal match rate of 58.27% and the 4% DRI inflation factor for facility costs.

Future Medicaid cost impacts from the changes to the CON limit proposed in this bill are largely unknown. The fiscal note reflects only projects that have been forwarded to the department for consideration. Actual costs could be much greater.

See next page for the breakdown of annual operating and depreciation costs of facilities reflected in this fiscal note.

DRAFT

CSHB 407(HES)
4/4/02

Estimated Cost of Potential New Projects Not Needing a CON Under CSHB 407/J

Nursing Home Beds:					Deprec. Exp.	Cost Per	New Annual
Timeline	Type	Location	Facility	No of Beds*	Or Facility Fee	Bed Day	Operating Costs
2005	C	Seward	Wesley R&C Ctr	66 NH Beds	$ 1,032,000	$ 389.46	
Acute Care Beds:							
2004	B	Mat-Su	Valley Hospital	75 Beds/37 new	$ 250,000	$ 1,625.97	$ 4,391,745
2003	B	ANCH	Providence	33 Beds	$ 250,000	$ 1,584.39	$ 3,816,796
2006	C	Soldotna	Central Pen. Hsp	62 Beds	$ 250,000	$ 1,559.13	
Other Acute Care Facilities:							
2003	B	FBKS	ASC/Diagnostic	4 Surg Suites	$ 200,000	Although there may be some operating costs for Medicaid, there is no way to estimate those costs	
2003	B	ANCH	ASC/Diagnostic	6 Surg Suites	$ 300,000		
2003	B	Mat-Su	ASC/Diagnostic	2 Surg Suites	$ 100,000		
2007	D	Soldotna	ASC/Diagnostic	2 Surg Suites	$ 100,000		
		Total Cost			$ 2,482,000		$ 8,208,540

* 70 New acute Beds; 100 Replacement acute beds; 66 Replacement Nursing Home Beds; and 14 new Ambulatory Surgery Suites

A= NH or Psych beds that can be built under $1 million threshold
B = Exempt from CON because facility is in Anch, Fbks, or Mat-Su and is Acute
C = Exempt from CON because it is a replacement facility
D = Facility in small community that will soon become a large community
E = Conversion of Psych Beds for Under $1 million

22-LS1389\F.3
Lauterbach
3/27/02

A M E N D M E N T

OFFERED IN THE HOUSE

TO: CSHB 407( ), Draft Version "F"

1 Page 1, line 1, following "**program;**":
2 Insert "**relating to children's mental health services;**"
3
4 Page 5, following line 30:
5 Insert a new bill section to read:
6 "* **Sec. 11.** AS 47.30.660 is amended by adding a new subsection to read:
7 (c) The plan prepared, revised, and amended under (a) of this section must
8 include, as a distinct component, a master plan for children's mental health services.
9 The master plan required under this subsection must be developed in conjunction with
10 the Alaska Mental Health Trust Authority, Alaska Mental Health Board, and Advisory
11 Board on Alcoholism and Drug Abuse, and must provide for involvement of families
12 of emotionally disturbed children and adolescents, community mental health
13 providers, and providers of residential and inpatient care for children and adolescents.
14 After gathering information through methods determined appropriate, the department
15 shall prepare the master plan, which must include the following:
16 (1) recommended principles that should be used to guide development
17 of a comprehensive system of care to meet the mental health needs of children and
18 adolescents;
19 (2) an estimate of the current and projected number of children and
20 adolescents in the state who are suffering severe emotional, mental, and substance
21 disorders;
22 (3) a description of the current system of care for children with
23 emotional, mental, and substance disorders, including the type, capacity, and

1 geographic availability of care;
2 (4) an assessment of the ability of the existing service system to meet
3 the identified and projected needs, including an assessment of utilization and factors
4 affecting utilization;
5 (5) an assessment of gaps in the type or capacity of services needed;
6 (6) the array and capacity of in-home, community-based, residential,
7 and inpatient care needed to meet the current and projected need for screening,
8 diagnosis, and treatment of children and adolescents in the state who are suffering
9 emotional, mental, and substance disorders;
10 (7) an analysis of impediments limiting or preventing development or
11 operation of the services and capacities needed;
12 (8) recommended priorities for action to reconfigure, expand, or
13 enhance existing services or to develop new service alternatives;
14 (9) an estimate of resources needed to develop and support the system
15 of services required."
16
17 Renumber the following bill sections accordingly.
18
19 Page 6, line 3:
20 Delete "secs. 1 - 11"
21 Insert "secs. 1 - 10 and 12"
22
23 Page 6, following line 5:
24 Insert a new bill section to read:
25 "* **Sec. 14.** The uncodified law of the State of Alaska is amended by adding a new section
26 to read:
27 MASTER PLAN FOR CHILDREN'S MENTAL HEALTH SERVICES. The initial
28 master plan required to be prepared under AS 47.30.660(c), added by sec. 11 of this Act, shall
29 be completed and delivered to the governor by the first day of the First Regular Session of the
30 Twenty-Third Alaska State Legislature, and the Department of Health and Social Services
31 shall notify the legislature that the master plan is available for review."

1

2 Renumber the following bill section accordingly.

22-LS1389\F.1
Lauterbach
3/22/02

AMENDMENT

OFFERED IN THE HOUSE

TO: CSHB 407( ), Draft Version "F"

1 Page 6, following line 5:
2 Insert a new bill section to read:
3 "* **Sec. 13.** The uncodified law of the State of Alaska is amended by adding a new section
4 to read:
5 TEMPORARY MORATORIUM ON CERTAIN PSYCHIATRIC BEDS. (a)
6 Notwithstanding the provisions of AS 18.07, the Department of Health and Social Services
7 may not, until July 1, 2003, issue a certificate of need for construction of a health care facility
8 that both
9 (1) includes psychiatric beds designated for children who are at least five
10 years of age but younger than 13 years of age or for adolescents who are at least 13 years of
11 age but younger than 20 years of age; and
12 (2) requires licensure under AS 18.20.020 as a general acute care hospital,
13 rural primary care hospital, critical access hospital, or specialized hospital primarily engaged
14 in the treatment of one specific type of illness or disability.
15 (b) The restriction in (a) of this section applies to applications for a certificate of need
16 for which a certificate was not issued before the effective date of this section."
17
18 Renumber the following bill section accordingly.

AMENDMENT NO. ____

OFFERED IN THE HOUSE HESS BY REPRESENTATIVE

TO: CSHB 407(HES)/Version F

[Shelby - @ Providence Hospital]

1 Page 2, following line 7:

2

3 *Sec. 2 AS 18.07.031(c) is amended to read:

4 (c) Notwithstanding (a) of this section, a person who is lawfully **authorized to**

5 **operate** [OPERATING] a health care facility [THAT IS AN AMULATORY

6 SURGICAL FACILITY] at a site may make an expenditure of any amount in order to

7 **replace the facility at the same site or** relocate the services of the facility to a new

8 site in the same community **by submitting a written request to the department for**

9 a certificate of need as long as neither the bed capacity nor the number of categories of

10 health services provided at the new site is greater **and no new category of health**

11 **services is provided. This certificate shall be issued within 60 days of written**

12 **request to the department.** However. notwithstanding the expenditure **thresholds,**

13 **population thresholds, and other provisions of** [THRESHOLD IN] (a) of this section,

14 a person may not use the site from which the health care facility relocated for another

15 health care facility unless authorized under a certificate of need issued by the department.

16 Renumber Sections as appropriate.

17 Page 6, line 3:

18 Delete "secs. 1 - 11"

19 Insert "secs. 1 – 12"

AMENDMENT NO. ___

OFFERED IN THE HOUSE HESS BY REPRESENTATIVE

TO: CSHB 407(HES)/Version F

(Elmer Lindstrom)

1 Page 2, following line 7:

2 Insert new bill section to read:

3 *Sec. 2 AS 18.07.031(b) is amended to read:

4 (b) Notwithstanding [THE EXPENDITURE THRESHOLD IN] (a) of this section, a

5 person may not **alter the bed capacity by adding new beds to, construct a building**

6 **for use as, or** convert a building or part of a building to a nursing home **or psychiatric**

7 **hospital** that requires licensure under AS 18.20.020 unless authorized under the terms of

8 a certificate of need issued by the department.

9

10 Renumber Sections as appropriate.

11 Page 6, line 3:

12 Delete "secs. 1 - 11"

13 Insert "secs. 1 – 12"

AMENDMENT NO. 1

OFFERED IN THE HOUSE HESS BY REPRESENTATIVE 11

TO: CSHB 407(HES)/Version F

Ray Gillespie

1 Page 2, following line 19:

2 Insert new bill section to read:

3 "*Sec. 3 AS 18.07.031 is amended by adding a new subsection to read:

4 (d) Notwithstanding the expenditure thresholds, population thresholds, and

5 other provisions of this section, a person may not convert the use of a bed in a health

6 care facility to another bed, including converting adult psychiatric beds to psychiatric

7 beds designated for adolescents and children, unless authorized under the terms of a

8 certificate of need issued by the department."

9

10 Renumber Sections as appropriate.

11 Page 6, line 3:

12 Delete "secs. 1 - 12"

13 Insert "secs. 1 – 13"

22-LS1389\F.3
Lauterbach
3/27/02

AMENDMENT

OFFERED IN THE HOUSE (Senator Green)

TO: CSHB 407( ), Draft Version "F"

1 Page 1, line 1, following "**program;**":
2 Insert "**relating to children's mental health services;**"
3
4 Page 5, following line 30:
5 Insert a new bill section to read:
6 "* **Sec. 11.** AS 47.30.660 is amended by adding a new subsection to read:
7 (c) The plan prepared, revised, and amended under (a) of this section must
8 include, as a distinct component, a master plan for children's mental health services.
9 The master plan required under this subsection must be developed in conjunction with
10 the Alaska Mental Health Trust Authority, Alaska Mental Health Board, and Advisory
11 Board on Alcoholism and Drug Abuse, and must provide for involvement of families
12 of emotionally disturbed children and adolescents, community mental health
13 providers, and providers of residential and inpatient care for children and adolescents.
14 After gathering information through methods determined appropriate, the department
15 shall prepare the master plan, which must include the following:
16 (1) recommended principles that should be used to guide development
17 of a comprehensive system of care to meet the mental health needs of children and
18 adolescents;
19 (2) an estimate of the current and projected number of children and
20 adolescents in the state who are suffering severe emotional, mental, and substance
21 disorders;
22 (3) a description of the current system of care for children with
23 emotional, mental, and substance disorders, including the type, capacity, and

1 geographic availability of care;
2 (4) an assessment of the ability of the existing service system to meet
3 the identified and projected needs, including an assessment of utilization and factors
4 affecting utilization;
5 (5) an assessment of gaps in the type or capacity of services needed;
6 (6) the array and capacity of in-home, community-based, residential,
7 and inpatient care needed to meet the current and projected need for screening,
8 diagnosis, and treatment of children and adolescents in the state who are suffering
9 emotional, mental, and substance disorders;
10 (7) an analysis of impediments limiting or preventing development or
11 operation of the services and capacities needed;
12 (8) recommended priorities for action to reconfigure, expand, or
13 enhance existing services or to develop new service alternatives;
14 (9) an estimate of resources needed to develop and support the system
15 of services required."
16
17 Renumber the following bill sections accordingly.
18
19 Page 6, line 3:
20 Delete "secs. 1 - 11"
21 Insert "secs. 1 - 10 and 12"
22
23 Page 6, following line 5:
24 Insert a new bill section to read:
25 "* **Sec. 14.** The uncodified law of the State of Alaska is amended by adding a new section
26 to read:
27 MASTER PLAN FOR CHILDREN'S MENTAL HEALTH SERVICES. The initial
28 master plan required to be prepared under AS 47.30.660(c), added by sec. 11 of this Act, shall
29 be completed and delivered to the governor by the first day of the First Regular Session of the
30 Twenty-Third Alaska State Legislature, and the Department of Health and Social Services
31 shall notify the legislature that the master plan is available for review."

1

2 Renumber the following bill section accordingly.

22-LS1389\F.3
Lauterbach
3/27/02

AMENDMENT #2

OFFERED IN THE HOUSE
TO: CSHB 407( ), Draft Version "F"

1 Page 1, line 1, following "**program;**":
2 Insert "**relating to children's mental health services;**"
3
4 Page 5, following line 30:
5 Insert a new bill section to read:
6 "* **Sec. 11.** AS 47.30.660 is amended by adding a new subsection to read:
7 (c) The plan prepared, revised, and amended under (a) of this section must
8 include, as a distinct component, a master plan for children's mental health services.
9 The master plan required under this subsection must be developed in conjunction with
10 the Alaska Mental Health Trust Authority, Alaska Mental Health Board, and Advisory
11 Board on Alcoholism and Drug Abuse, and must provide for involvement of families
12 of emotionally disturbed children and adolescents, community mental health
13 providers, and providers of residential and inpatient care for children and adolescents.
14 After gathering information through methods determined appropriate, the department
15 shall prepare the master plan, which must include the following:
16 (1) recommended principles that should be used to guide development
17 of a comprehensive system of care to meet the mental health needs of children and
18 adolescents;
19 (2) an estimate of the current and projected number of children and
20 adolescents in the state who are suffering severe emotional, mental, and substance
21 disorders;
22 (3) a description of the current system of care for children with
23 emotional, mental, and substance disorders, including the type, capacity, and

L

1 geographic availability of care;

2 (4) an assessment of the ability of the existing service system to meet
3 the identified and projected needs, including an assessment of utilization and factors
4 affecting utilization;

5 (5) an assessment of gaps in the type or capacity of services needed;

6 (6) the array and capacity of in-home, community-based, residential,
7 and inpatient care needed to meet the current and projected need for screening,
8 diagnosis, and treatment of children and adolescents in the state who are suffering
9 emotional, mental, and substance disorders;

10 (7) an analysis of impediments limiting or preventing development or
11 operation of the services and capacities needed;

12 (8) recommended priorities for action to reconfigure, expand, or
13 enhance existing services or to develop new service alternatives;

14 (9) an estimate of resources needed to develop and support the system
15 of services required."

16

17 Renumber the following bill sections accordingly.

18

19 Page 6, line 3:

20 Delete "secs. 1 - 11"

21 Insert "secs. 1 - 10 and 12"

22

23 Page 6, following line 5:

24 Insert a new bill section to read:

25 "* **Sec. 14.** The uncodified law of the State of Alaska is amended by adding a new section
26 to read:

27 MASTER PLAN FOR CHILDREN'S MENTAL HEALTH SERVICES. The initial
28 master plan required to be prepared under AS 47.30.660(c), added by sec. 11 of this Act, shall
29 be completed and delivered to the governor by the first day of the First Regular Session of the
30 Twenty-Third Alaska State Legislature, and the Department of Health and Social Services
31 shall notify the legislature that the master plan is available for review."

1

2 Renumber the following bill section accordingly.

Sectional for CSHB 407(HSS)
Version O

***Section 1.** (a)(1) This provision specifically provides that if a facility is operating under a certificate of need, that facility cannot, **for any amount**, construct a skilled nursing facility or psychiatric hospital, increase the bed capacity of a skilled nursing facility, nor convert a building or part of a building to a skilled nursing facility or psychiatric hospital. It also prohibits the conversion of adult psychiatric beds to psychiatric beds designated for care of a child under 21 years of age. This language requires a CON for skilled nursing facilities and psychiatric hospitals.

(a)(2) This provision stipulates that a skilled nursing facility or a psychiatric hospital wishing to add health services that would cost $1 million or more would have to apply for an additional CON to do so.

It also exempts from the CON provisions any health facility other than a skilled nursing facility or psychiatric hospital in an area with a population of 55,000 or more.

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

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

Section 4. Requires the department to set a time limit by which public hearings must be held.

Requires the department to approve or deny an application within 120 days of the date the department determined the application was complete.

Section 5. Places all certificate of need applications under the same standards of review that currently exist for nursing home beds. All CON's except nursing homes had a vague standard of review under AS 18.07.041. This change gives a more definitive standard for the applicants to follow.

Sections 6 Thru 10. Technical changes required under Section 5.

Section 11. Repeals the broad standard of review in AS 18.07.041 and repeals 18.07.031(b) which is now AS 18.07.031(a)(1)(C) and is expanding the restrictions to psychiatric hospitals.

Section 12. Applicability of new statute is limited to CON applications filed on or after the effective date.

Section 13. Has an immediate effective date.

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS HB 407 (HES)
( ) Publish Date:

Revision Date/Time (Note if correction):
Title: RELATING TO CERTIFICATES OF NEED

Dept. Affected: Health & Social Services
BRU: Administrative Services
Component: Health Plan. & Facilities Mgmt

Sponsor: COGHILL
Requestor: HOUSE (HES)

Component Number: 2020

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services	38.0					
Travel	8.0					
Contractual	53.5					
Supplies	1.0					
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	100.5	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
1002 Federal Receipts						
1003 GF Match						
1004 GF	100.5					
1005 GF/Program Receipts						
1037 GF/Mental Health						
Othe (Specify Type--do not abbrevia						
TOTAL	100.5	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2002) cost:

Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary	1					

ANALYSIS: *(Attach a separate page if necessary)*

The amendment to HB 407 endorses the development of a comprehensive health plan that uses existing health plans and focuses on the development of community specific health information to assist the Certificate of Need program in evaluating Certificate of Need applications. This plan is similar to the "State Health Plan for Alaska" last published in 1984 but would be less comprehensive and very specific to health care facilities that might be reviewed by the Certificate of Need program. The plan will build on existing statewide health plans such as Healthy Alaskans 2010 and In Step, the Comprehensive Integrated Mental Health Plan.

The health facilities plan would include data on statewide and regional utilization of each type of service, existing service capacity, cost information, comparative data from other states, health system

Prepared by: Kathryn Cohen Phone 465-3644
Division Admin Services Date/Time 04/10/2002
Approved by: Elmer A. Lindstrom, Deputy Commissioner Date 04/10/2002
Agency Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

FISCAL NOTE #

STATE OF ALASKA
2002 LEGISLATIVE SESSION

BILL NO. CS HB 407 (HES)

ANALYSIS CONTINUATION

research and discussion of continuum of care issues including how the development of or lack of lower levels of care effect certain types of inpatient services. Financial data, efficiency and quality of care issues will also be explored. The proposed amendment requires a report to be submitted to the Legislature by January 1, 2003. This will require the addition of a Health and Social Services Planner II to help write the document, assist in research and facilitate planning meetings. A Health Facilities Planning Consultant with specialized expertise will also be needed to help research current trends, project future needs, conduct utilization research and provide specialized analysis of systems issues such as waiting lists and out of state placements in areas such as psychiatric services and long term care.

Planning will require cooperation with existing planning entities at the state and local level. The Healthy Alaskans Partnership Council will provide overall plan guidance. Planners will consult with the Hospital and Nursing Home Association, Alaska Medical Association, Alaska Native Health Board, Advisory Board on Alcoholism and Drug Abuse, Alaska Mental Health Board, Governor's Council on Disabilities and Special Education, and the Alaska Commission on Aging. The draft plan will be circulated for public comment for 45 days and public meetings will be held in Anchorage, Fairbanks and Juneau. A report will be submitted to the Legislature by January 1, 2003.

Operating Expenditures for Plan Development
July 1, 2002 - January 31, 2003

Personal Services
Addition of temporary Health and Social Services Planner II (7 months) = $38,000
Travel = $8,000
Health Facility Planning Consultant = $50,000
Publication Costs draft and final, 500 copies @$6.00/copy = $3,500
Supplies: $1,000
Total = $100,500

22-LS1389\P
Lauterbach
4/11/02

CS FOR HOUSE BILL NO. 407( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES COGHILL, James, Scalzi, Dyson

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the certificate of need program; relating to comprehensive health**
2 **planning; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 18.07.031(a) is repealed and reenacted to read:
5 (a) Except as provided in (c) of this section, a person may not, unless
6 authorized under the terms of a certificate of need issued by the department, make an
7 expenditure of
8 (1) any amount for
9 (A) construction of a skilled nursing facility or psychiatric
10 hospital;
11 (B) an increase in the bed capacity of a skilled nursing facility
12 or psychiatric hospital;
13 (C) conversion of a building or part of a building to a skilled
14 nursing facility or psychiatric hospital;

1 (D) conversion of a bed in a health care facility to a psychiatric
2 bed designated for care of a child under 21 years of age;
3 (E) conversion of the existing use of a bed in a health care
4 facility to a new bed use other than new use as a psychiatric bed designated for
5 the care of a child under 21 years of age if the existing use required a
6 certificate of need at the time the use was established and the health care
7 facility is located in the unorganized borough or in an organized borough with
8 a population of less than 55,000 at the time of the proposed conversion,
9 according to the latest reliable data approved by the Department of Community
10 and Economic Development; or
11 (2) $1,000,000 or more for
12 (A) addition of a category of health services provided by a
13 skilled nursing facility or a psychiatric hospital; or
14 (B) construction of a health care facility other than a skilled
15 nursing facility or psychiatric hospital, alteration of the bed capacity of a health
16 care facility other than a skilled nursing facility or psychiatric hospital, or
17 addition of a category of health services provided by a health care facility other
18 than a skilled nursing facility or psychiatric hospital, if the health care facility
19 is located in the unorganized borough or in an organized borough with a
20 population of less than 55,000 at the time of commencement of activities,
21 according to the latest reliable data approved by the Department of Community
22 and Economic Development.
23 * **Sec. 2.** AS 18.07.031(c) is amended to read:
24 (c) Notwithstanding (a) of this section, a person who is lawfully **authorized to**
25 **operate** [OPERATING] a health care facility [THAT IS AN AMBULATORY
26 SURGICAL FACILITY] at a site may make an expenditure of any amount in order to
27 **replace the facility at the same site or** relocate the services of that facility to a new
28 site in the same community without obtaining a certificate of need as long as neither
29 the bed capacity nor the number of categories of health services provided at the new
30 site **or in the new facility** is greater**, the percentage of beds designated for each**
31 **type of use at the new site or in the new facility is not different from the**

1 **percentage of beds designated for that type of use at the old site or in the previous**
2 **facility, and no new category of health services is provided at the new site or in**
3 **the new facility**. However, [NOTWITHSTANDING THE EXPENDITURE
4 THRESHOLD IN (a) OF THIS SECTION,] a person may not use the site from which
5 the health care facility relocated for another health care facility unless **the person**
6 **complies with the** [AUTHORIZED UNDER A] certificate of need **requirements of**
7 **(a) of this section** [ISSUED BY THE DEPARTMENT].
8 * **Sec. 3.** AS 18.07.035 is amended to read:
9 **Sec. 18.07.035. Application and fees.** Application for a certificate of need
10 shall be made to the department upon a form provided by the department and must
11 contain the information the department requires to reach a decision **about whether to**
12 **issue the certificate of need** [UNDER THIS CHAPTER]. Each application for a
13 certificate of need must be accompanied by an application fee established by the
14 department by regulation. **The department shall, by regulation, set a time limit by**
15 **which the department shall determine whether an application submitted under**
16 **this section is complete and contains all of the information the department**
17 **requires to reach a decision about whether to issue the certificate of need.**
18 * **Sec. 4.** AS 18.07 is amended by adding new sections to read:
19 **Sec. 18.07.037. Public hearing required.** Except as provided in
20 AS 18.07.071, the department shall hold a public hearing within a reasonable time
21 after determining that an application under AS 18.07.035 is complete. By regulation,
22 the department shall establish
23 (1) a time limit by which a public hearing required under this section
24 shall be held; and
25 (2) procedures for conducting a public hearing held under this section.
26 **Sec. 18.07.039. Time limit for decision on application.** Based on the
27 standards for review under this chapter, the department shall, within 120 days after
28 determining that an application under AS 18.07.035 is complete, approve or deny the
29 application.
30 * **Sec. 5.** AS 18.07.043 is amended to read:
31 **Sec. 18.07.043. Standard of review for applications for certificates of need**

1 **and applications to modify certificates of need** [RELATING TO NURSING
2 HOMES AND NURSING HOME BEDS]. (a) The department shall develop
3 review standards for an application for a certificate of need, or for a modification of a
4 certificate of need, issued under this chapter [FOR A HEALTH CARE FACILITY
5 THAT IS A NURSING HOME OR HAS NURSING HOME BEDS].
6 (b) **When determining whether to approve an application for a new**
7 **certificate of need or to modify an existing certificate of need** [IN DEVELOPING
8 THE REVIEW STANDARDS UNDER (a) OF THIS SECTION], the department **may**
9 **consider community-specific health information that may be available in a**
10 **comprehensive health plan prepared by the department under AS 47.05.010(b)**
11 **and** shall consider whether
12 (1) a public process and existing appropriate statewide, regional, and
13 local plans were included in planning and designing the **project** [ADDITIONAL
14 NURSING HOME BEDS OR THE HEALTH CARE FACILITY];
15 (2) the **project will meet** [ADDITIONAL NURSING HOME BEDS
16 OR THE HEALTH CARE FACILITY MEETS] minimum required use rates for **the**
17 **proposed services without causing the** [NEW NURSING BEDS, AND THE
18 EFFECT ON] use rates for existing **providers of the services to fall below minimum**
19 **required use rates** [NURSING HOME BEDS];
20 (3) the **project** [ADDITIONAL NURSING HOME BEDS OR THE
21 HEALTH CARE FACILITY] demonstrates consideration of the community, regional,
22 and statewide needs [FOR NEW NURSING HOME BEDS];
23 (4) the **project** [ADDITIONAL NURSING HOME BEDS OR THE
24 HEALTH CARE FACILITY] meets the minimum **standards of the department that**
25 **are designed** [NUMBER OF NEW NURSING BEDS THAT SHOULD BE
26 REQUIRED IN A FACILITY] to ensure efficiency and economies of scale;
27 (5) the **project** [ADDITIONAL NURSING HOME BEDS OR THE
28 HEALTH CARE FACILITY] demonstrates the proposed service will provide a
29 quality of care equivalent to existing community, regional, or statewide services;
30 (6) the **project** [ADDITIONAL NURSING HOME BEDS OR THE
31 HEALTH CARE FACILITY] demonstrates financial feasibility, including long-term

1 viability, and what the financial effect will be on consumers and the state; and
2 (7) the sponsor has demonstrated cost effectiveness through
3 considering the availability of appropriate, less costly alternatives of providing the
4 services planned.
5 (c) The department shall grant a sponsor a certificate of need or modify a
6 certificate of need [THAT AUTHORIZES NURSING HOME BEDS OR THAT IS
7 FOR A HEALTH CARE FACILITY THAT IS A NURSING HOME] if the
8 department finds that the sponsor meets the standards established in or under this
9 chapter.
10 * **Sec. 6.** AS 18.07.071(b) is amended to read:
11 (b) The department may grant a sponsor a temporary certificate for the
12 temporary operation of a category of health service if the sponsor shows by affidavit
13 or formal hearing
14 (1) the necessity for early, immediate, or temporary relief; and
15 (2) adverse effect to the public interest by reason of delay occasioned
16 by compliance with the requirements of **AS 18.07.043** [AS 18.07.041, 18.07.043,] and
17 application procedures prescribed by regulations under this chapter.
18 * **Sec. 7.** AS 18.07.071(c) is amended to read:
19 (c) A temporary certificate granted under (b) of this section does not confer
20 vested rights on behalf of the applicant. The department shall impose those special
21 limitations and restrictions concerning duration and right of extension that the
22 department considers appropriate. A temporary certificate may not be granted for a
23 period longer than necessary for the sponsor to obtain review of the action certified by
24 the temporary certificate under AS 18.07.051. Application for a certificate of need
25 **that will be reviewed** under **AS 18.07.043** [AS 18.07.041 OR 18.07.043] must
26 commence within 60 days **after** [OF] the date of issuance of the temporary certificate.
27 * **Sec. 8.** AS 18.07.081(c) is amended to read:
28 (c) A certificate of need shall be suspended if an accusation is filed before the
29 commencement of activities authorized under **AS 18.07.043** [AS 18.07.041 OR
30 18.07.043] that charges that factors upon which the certificate of need was issued have
31 changed or new factors have been discovered that significantly alter the need for the

1 activity authorized. A suspension of a certificate may not exceed 60 days. At the end
2 of this period or sooner, the department shall revoke or reinstate the certificate.
3 * **Sec. 9.** AS 18.07.081(d) is amended to read:
4 (d) A certificate of need may be revoked if
5 (1) the sponsor has not shown continuing progress toward
6 commencement of the activities authorized under **AS 18.07.043 within** [AS 18.07.041
7 OR 18.07.043 AFTER] six months **after the date** of issuance **of the certificate;**
8 (2) the applicant fails, without good cause, to complete activities
9 authorized by the certificate;
10 (3) the sponsor fails to comply with [THE PROVISIONS OF] this
11 chapter or regulations adopted under this chapter;
12 (4) the sponsor knowingly misrepresents a material fact in obtaining
13 the certificate;
14 (5) the facts charged in an accusation filed under (c) of this section are
15 established; or
16 (6) the sponsor fails to provide services authorized by the terms of the
17 certificate.
18 * **Sec. 10.** AS 18.07.111(2) is amended to read:
19 (2) "certificate" means a certificate of need issued by the department
20 under **AS 18.07.043 or 18.07.071** [AS 18.07.041, 18.07.043, OR 18.07.071];
21 * **Sec. 11.** AS 47.05.010 is amended by adding a new subsection to read:
22 (b) The department shall develop a comprehensive health plan for the state.
23 To the maximum extent possible, the department shall compile the plan from
24 information available to the department from its data bases, from the data bases of
25 other agencies, and from local community efforts. The department shall prepare the
26 plan in a manner designed to enable the department to use community-specific health
27 information in the plan to assist the department in evaluating applications for
28 certificates of need submitted under AS 18.07 as well as for other purposes.
29 * **Sec. 12.** AS 18.07.031(b) and 18.07.041 are repealed.
30 * **Sec. 13.** The uncodified law of the State of Alaska is amended by adding a new section to
31 read:

1 COMPREHENSIVE HEALTH PLAN; DUE DATE. The plan required under
2 AS 47.05.010(b), enacted by sec. 11 of this Act, shall be prepared by the Department of
3 Health and Social Services by January 1, 2003, and a copy of it shall be given by the
4 department to the legislature by that date.
5 * **Sec. 14.** The uncodified law of the State of Alaska is amended by adding a new section to
6 read:
7 APPLICABILITY. AS 18.07, as amended by secs. 1 - 10 and 12 of this Act, applies
8 to applications for certificates of need that are initially filed on or after the effective date of
9 this Act.
10 * **Sec. 15.** This Act takes effect immediately under AS 01.10.070(c).

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

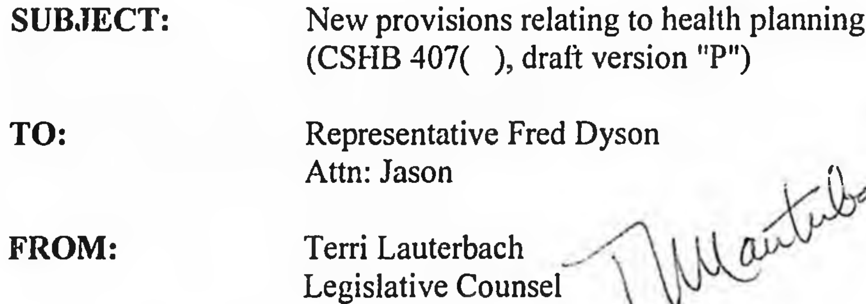
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 11, 2002

SUBJECT: New provisions relating to health planning
(CSHB 407( ), draft version "P")

TO: Representative Fred Dyson
Attn: Jason

FROM: Terri Lauterbach
Legislative Counsel



Enclosed is the blank CS you requested.

The material you asked me to add to the "O" version of the bill was a combination of temporary and permanent law. Although the comprehensive plan is, as I understand it, supposed to be prepared only once and a copy of it is due by a certain date, the plan itself has ongoing applicability because it is supposed to be used to help implement the certificate of need program. That is a permanent effect. With the approval of your staff, therefore, I have split the material up so that some of it will appear in the general statutes and some of it will only appear in the temporary laws.

The permanent material is added in the following places: on page 4 just before paragraph (1), and on page 6 as a new section 11.

The temporary material is in new section 13.

If I may be of further assistance, please advise.

TML:med
02-367.med

Enclosure

<u>AMENDMENT #</u>

OFFERED IN THE HOUSE HESS BY REPRESENTATIVE COGHILL

TO: CSHB 407(HSS)) Version P

1 Page 1, line 1, following "**program;**":
2 Insert "**relating to comprehensive health planning;**"
3
4 Page 7: Delete lines 1 – 4.
5
6 Page 7, line 1:
7 Insert:
8 COMPREHENSIVE HEALTH PLAN; LIMITATIONS. The plan required under
9 AS 47.05.010(b), enacted by sec. 11 of this Act,
10 (1) It is not intended by the legislature to be updated periodically;
11 (2) shall be prepared by the Department of Health and Social Services by
12 January 1, 2003, and a copy of it shall be given by the department to the legislature
13 by that date: and
14 (3) shall be prepared by using staff and other resources of the department that
15 are generally available to perform the duties of the department without an additional
16 appropriation specifically designated for preparation of the plan."

Attn: T. Lauterbach

From Jason Hooley
HHES Committee Aide to Rep Dyson
Rm 106 , x 3759

AMENDMENT # 1

OFFERED IN THE HOUSE HESS BY REPRESENTATIVE COGHILL

TO: CSHB 407(HSS) Version

1 Page 7: Delete lines 1 – 4.

2

3 Page 7, line 1:

4 Insert:

5 COMPREHENSIVE HEALTH PLAN; LIMITATIONS. The plan required under

6 AS 47.05.010(b), enacted by sec. 11 of this Act,

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

8 (2) shall be prepared by the Department of Health and Social Services by

9 January 1, 2003, and a copy of it shall be given by the department to the legislature

10 by that date: and

11 (3) shall be prepared by using staff and other resources of the department that

12 are generally available to perform the duties of the department without an additional

13 appropriation specifically designated for preparation of the plan or without an additional

14 appropriation to fund indirect impact of existing personnel or resources."

please add this amendment to Version P ~~and~~ of HB 407 (22-LS1389\P) ~~as~~ the FINAL draft, HES Committee Substitute. This bill passed yesterday.

Thank you!

A.A. Pain Clinic, Inc.
4100 Lake Otis Pkwy
Suite 216
Anchorage, AK 99508
907-563-2873 phone
907-563-5852 fax

Fax

To:	Fred Dyson	From:	Leon Chandler
Fax:	907-465-4587	Pages:	9
Phone:		Date:	4/10/02
Re:	HB407	CC:	

☐ Urgent X For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Please review the following information as an addition to my previous testimony.

Thank you for your time and consideration.

April 10, 2002

Fred Dyson
House Bill 407
Legislative Session Contact
State Capitol, Room 104
Juneau, AK 99801-1182

Dear Representative,.

I testified by telephone several weeks ago about the certificate of need that is currently before the HESS committee. That testimony should be available to you. I am writing to you to support information I gave during that testimony for information on the health care system for Providence Hospital and their financial situation. Al Parrish testified in our trial, through his deposition on 8/24/00 and under questioning, he testified about several things that were related to the health care system at Providence in Alaska.

At that time, Mr. Parrish was the financial chairman of the Providence board and had access to all financial information for Providence. He had been on the board from 1990 to 1991 up until that date in 2000, when he testified. On pages 19 and 20 of his deposition, referance to Arthur Andersen's auditors report (pages 01613) 1996 earnings of Providence Alaska Health System was $35,000,454. In 1999, under the strategic plan report, their earnings were $46,937,000. Projections for earnings in the year 2001 from that same report were $55 million. Investment of funds returned for them was [illegible] at 7.9%, according to page 01627. These monies were in reference to the Providence Foundation and all of the monies of the Providence Health Care System, Alaska.
In 1994, the Medical Rate Advisory Commission (copy inclosed) stated that Providence had 70% of the patient base in the Anchorage market place during 1994 and at that increased to 80% in the year 1998. This was shown in Exhibit #56 in the court file. Mr. Parrish testified ownership of other medical services in Anchorage, included Providence Extended Care, Mary Conrad Center, Horizon House, Providence Home Health Care System, Alaska Family Residence Program, Providence Behavioral Medical Group Services, Physical Partners, Community Partners, and Kodiak Management System of Providence. The Imaging Center was questioned, but not answered whether it was owned by Providence or not.

In the 1990 the Providence Strategic Plan on page 25, which is (Providence page 1412), talked about Providence saying, "Individual programs have seen declines in market share over the last three years, 1987-1989. Surgery declined 4% to 64%." Mr. Parrish testified that he thought this would mean that 67-68% of the market share was Providence's share during the 1986-87 region.

Hess (SB256-CON)

94=70%

98 = 80%

Department of Health and Social Services
Medicaid Rate Advisory Commission

Municipality of Anchorage Community Planning and Development Department
Statistics Request for Alaska Regional Hospital and Providence Hospital

FY 1998

FACILITY	BEDS ACUTE	BEDS NURSERY	BEDS NICU	BEDS TOTAL	ADMISSIONS ACUTE	ADMISSIONS NURSERY	ADMISSIONS NICU	ADMISSIONS TOTAL	PATIENT DAYS ACUTE	PATIENT DAYS NURSERY	PATIENT DAYS NICU	PATIENT DAYS TOTAL
Alaska Regional	166	33	0	199	4,572	453		5,025	20,533	1,648		22,181
Providence	303	24	38	365	14,045	2,403	406	16,854	66,986	4,267	9,507	80,760
COMBINED	469	57	38	564	18,617	2,856	406	21,879	87,519	5,915	9,507	102,941

FY 1998

FACILITY	OCCUPANCY RATE	AVERAGE STAY
Alaska Regional	30.5%	4.4
Providence	60.6%	4.8
COMBINED	50.0%	4.7

80760 of total 102941

> 70% of pt days -

estimate 55 mil 2001

99 - 46,937,000.

since 92 profitable -

1989 - Document - 64% of the Market Share - down 4%

So 98 → was 68%

Department of Health and Social Services
Medicaid Rate Advisory Commission

Municipality of Anchorage Community Planning and Development Department
Statistics Request for Alaska Regional Hospital and Providence Hospital

FY 1997

FACILITY	BEDS ACUTE	BEDS NURSERY	BEDS NICU	BEDS TOTAL	ADMISSIONS ACUTE	ADMISSIONS NURSERY	ADMISSIONS NICU	ADMISSIONS TOTAL	PATIENT DAYS ACUTE	PATIENT DAYS NURSERY	PATIENT DAYS NICU	PATIENT DAYS TOTAL
Alaska Regional	153	7		160	4,966	840	0	5,806	23,364	1,684	0	25,048
Providence	303	24	38	365	13,697	2,414	379	16,490	64,333	3,924	10,124	[illegible]
COMBINED	456	31	38	525	18,663	3,254	379	22,296	87,697	5,608	10,124	103,429

FY 1997

FACILITY	OCCUPANCY RATE	AVERAGE STAY
Alaska Regional	42.9%	4.3
Providence	58.8%	4.8
COMBINED	54.0%	4.6

78381 / 103429

Department of Health and Social Services
Medicaid Rate Advisory Commission

Municipality of Anchorage Community Planning and Development Department
Statistics Request for Alaska Regional Hospital and Providence Hospital

FY 1996

FACILITY	BEDS				ADMISSIONS				PATIENT DAYS			
	ACUTE	NURSERY	NICU	TOTAL	ACUTE	NURSERY	NICU	TOTAL	ACUTE	NURSERY	NICU	TOTAL
Alaska Regional	153	7		160	5,227	739	0	5,966	22,879	1,267	0	24,146
Providence	303	24	38	365	12,463	2,083	390	14,936	61,530	3,238	9,840	74,608
COMBINED	456	31	38	525	17,690	2,822	390	20,902	84,409	4,505	9,840	98,754

74,608 / 98,754 of

FY 1996

FACILITY	OCCUPANCY RATE	AVERAGE STAY
Alaska Regional	41.3%	4.0
Providence	56.0%	5.0
COMBINED	51.5%	4.7

96 — 35,454 ORD learns

NOA96

Department of Health and Social Services
Medicaid Rate Advisory Commission

Municipality of Anchorage Community Planning and Development Department
Statistics Request for Alaska Regional Hospital and Providence Hospital

FY 1995

FACILITY	BEDS ACUTE	BEDS NURSERY	BEDS NICU	BEDS TOTAL	ADMISSIONS ACUTE	ADMISSIONS NURSERY	ADMISSIONS NICU	ADMISSIONS TOTAL	PATIENT DAYS ACUTE	PATIENT DAYS NURSERY	PATIENT DAYS NICU	PATIENT DAYS TOTAL
Alaska Regional	256	30		286	5,355	952	0	6,307	23,629	1,401	0	25,030
Providence	303	24	38	365	12,365	2,271	359	14,995	60,866	3,369	7,751	71,986
COMBINED	559	54	38	651	17,720	3,223	359	21,302	84,495	4,770	7,751	97,016

FY 1995

FACILITY	OCCUPANCY RATE	AVERAGE STAY
Alaska Regional	24.0%	4.0
Providence	54.0%	4.8
COMBINED	40.3%	4.6

71,986
of 97,016

MarSS

Department of Health and Social Services
Medicaid Rate Advisory Commission

Municipality of Anchorage Community Planning and Development Department
Statistics Request for Alaska Regional Hospital and Providence Hospital

FY 1994

FACILITY	BEDS ACUTE	BEDS NURSERY	BEDS NICU	BEDS TOTAL	ADMISSIONS ACUTE	ADMISSIONS NURSERY	ADMISSIONS NICU	ADMISSIONS TOTAL	PATIENT DAYS ACUTE	PATIENT DAYS NURSERY	PATIENT DAYS NICU	PATIENT DAYS TOTAL
Alaska Regional	238	35	0	273	5,273	1,035	0	6,308	24,507	1,551	0	26,058
Providence	303	24	35	362	11,836	2,394	401	14,631	58,450	3,610	8,485	70,545
COMBINED	541	59	35	635	17,109	3,429	401	20,939	82,957	5,161	8,485	96,603

FY 1994

FACILITY	OCCUPANCY RATE	AVERAGE STAY
Alaska Regional	26.2%	4.1
Providence	53.4%	4.6
COMBINED	41.7%	4.6

70,545
-96,603

EXHIBIT
56
Parrish

NOA98

Letter from Leon H. Chandler, Jr., MD
Page two

In the 1990 Strategic plan, it also states on page 27 (Providence page 1414), under the heading of Financial, "Corporate expects Sisters of Providence facilities to earn 5 to 6 net percent, net return of revenue." When Mr. Parrish was asked what the actual revenues were for Providence Health Care Systems, he stated it would be between $2.5 billion and $3 billion dollars. Mr. Parrish then testified that the return he felt comfortable with on that amount of revenue had been between 1 and 3% net return on the total between $2.5 billion and $3.5 billion, or thereabouts.

On page 33 of the same strategic plan (Providence page 1496), it stated, "The Sisters of Providence System is the largest private provider of health care in Alaska." It goes on to say, on page 34 of the same report (Providence page 1497), "The Task Force recognizes that our size and dominance of Alaska health care causes some to see us in a way that hampers efforts to develop collaborative, trusting relationships with external entities." When Mr. Parrish was asked about this, his response was that his assumption was that the meaning of this paragraph was that Providence was the largest institution or delivery system in Alaska for healthcare in 1992. On that same strategic plan, page 1502, under the heading of Public Relations it says, "The public image, reputation of the Sisters of Providence Facilities in Alaska is good, although there are always some who find fault and feel threatened by our dominance and active stance in the continued development of our facilities and services." Mr. Parrish was asked by attorney if he had information as to whether or not the dominance of Alaska had become greater or less since 1992, and Mr. Parrish felt that he did not know; however, he felt certain that the area administrator, or administrator of the hospital would know that, and those persons were Doug Bruce and Gene O'Hara.

When Mr. Parrish was asked in his deposition, how big a lawsuit settlement would have to be before it would be discussed by the board, under page 49, line 23 and 24, and his response was, "Well, if it had multiple ramifications in other areas, it was a substantial impact to the financial statements, in excess maybe, you know, 3, 4, or 5 million, something like that, it was not covered by insurance in some fashion, the Board would begin to – or our legal department would then begin to advise the Board. I can't tell you specifically what the parameters, what the reporting responsibilities or the matrix is, but there is a matrix that, I think, says, okay, here's what you need to bring it to the Board level."

The next question by the attorney was, "So, unless the exposure was $3 to $5 million or so, it wouldn't see the Board's attention?" Answer: "Well, I'd have to look at the matrix. There is a matrix that says, okay, here's what's within the management purview, and anything above that, those thresholds, need to be brought to the Board or the Finance Committee, depending on the competency levels are, in references to the financial issues."

If there is any question of whether Providence Hospital is making money, it was estimated from this testimony that Providence would make $55 million above all expenses in the year 2001. Overall, Providence system wide revenues was estimated to be as high as 6% of the gross revenue. The total revenues were estimated by Mr. Parrish to be between 2.5 billion and 3.5 billion systems wide, you can do the math.

This information is for the education of the committee members and is available in public information as a result of the lawsuit I filed against Providence Hospital. The jury verdict was unanimous on all counts. This included the Sherman Antitrust and treble damaged were awarded by the court. The judgment is approximately 2 million, which is not high enough to even get to the Board of the Providence Health Care System involved, as stated by Mr. Parrish. This judgement is currently being appealed by Providence.

Thank you very much for your time. If I can be of further assistance with my efforts for this lawsuit and information that has been made available to you, please contact me and I will be happy to discuss this with you at any time.

Sincerely,

Leon H. Chandler, Jr., MD
LHC: tw