HB
287

Alaska State Legislature

Chairman
Military & Veterans' Affairs Committee

Member
Labor and Commerce Committee
State Affairs Committee
Economic Development, Trade & Tourism Committee
Education Committee
Joint Armed Services Committee

Finance Subcommittees
Labor & Workforce Development
Community & Economic Development
Military & Veterans' Affairs

A Communication From
REPRESENTATIVE BOB LYNN
District 31 Anchorage

Representative_Bob_Lynn@legis.state.ak.us

Session:
Alaska State Capitol
Juneau, AK 99801-1182

Phone (907) 465-4931
Fax (907) 465-4316
Toll Free (800) 870-4391

Interim:
716 W. 4th Ave., #650
Anchorage, AK 99501-2133

Phone (907) 269-0205
Fax (907) 269-0207

SPONSOR STATEMENT HB 287

Medical Facilities Certificate of Need

By Representative Bob Lynn

Free enterprise motivates excellence, encourages competitive prices, and benefits consumers. The beneficial principles of free enterprise apply to businesses large or small: hot dog stands, automobile manufacturers, as well as health care facilities, and nursing homes.

HB287 removes the current requirement for a Certificate of Need for health care facilities and nursing homes in a borough with a population of more than 25,000. In other words, a Certificate of Need would not be required for a health care facility or nursing home in Anchorage, Fairbanks, Juneau, Matsu and Kenai. Smaller communities would still require, as a practical matter, the Certificate of Need.

Competition typically lowers prices. Passage of HB287 would help lower the escalating costs of Workers' Compensation, PERS/STRS, Medicaid, and the cost and availability for Alaskan companies and individuals.

The free marketplace should decide if a business is needed, not the government. A health care facility or nursing home should not have to beg for a government issued Certificate of Need to open a business, so as to protect similar businesses from healthy competition. Medical facilities and nursing homes keep patients healthy; competition keeps the economy healthy.

Medical costs in Alaska have reached crisis levels. It is past time to restore American competition and freedom of choice for the benefit of Alaska's medical consumers.

Your support of HB 287 is respectfully requested

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2/13/06

CS FOR HOUSE BILL NO. 287( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES LYNN, Coghill, Chenault, Kohring

A BILL

FOR AN ACT ENTITLED

1 **"An Act amending the certificate of need requirements to apply only to health care**
2 **facilities that are nursing homes or residential psychiatric treatment centers or that are**
3 **located in a borough with a population of not more than 25,000, in the unorganized**
4 **borough, or in a community with a critical access hospital."**

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

6 * **Section 1.** AS 18.07.031(a) is amended to read:
7 (a) Except as provided in **(c), (d) and (g)** [(c) AND (d)] of this section, a
8 person may not make an expenditure of $1,000,000 or more for any of the following
9 **in a borough with a population of not more than 25,000, in the unorganized**
10 **borough, or in a community in which a facility has been designated by the**
11 **department as a critical access hospital,** unless authorized under the terms of a
12 certificate of need issued by the department:
13 (1) construction of a health care facility;
14 (2) alteration of the bed capacity of a health care facility; or

1 (3) addition of a category of health ser ices provided by a health care
2 facility.
3 * **Sec. 2.** AS 18.07.031(b) is amended to read:
4 (b) Notwithstanding the expenditure threshold in **(g)** [(a)] of this section, a
5 person may not convert a building or part of a building to a nursing home that requires
6 licensure as a nursing facility under AS 47.32 unless authorized under the terms of a
7 certificate of need issued by the department.
8 * **Sec. 3.** AS 18.07.031 is amended by adding new subsections to read:
9 (f) In this section, reference to the department's designation of a facility as a
10 critical access hospital means action taken by regulatory authority exercised under
11 AS 18.05 or AS 18.20 by which a facility eligible for designation as a critical access
12 hospital has been so identified.
13 (g) Notwithstanding the limitations in (a) of this section, a person may not
14 make an expenditure of $1,000,000 or more for any of the following unless authorized
15 under the terms of a certificate of need issued by the department:
16 (1) construction of a nursing home or residential psychiatric treatment
17 center;
18 (2) alteration of the bed capacity of a nursing home or residential
19 psychiatric treatment center; or
20 (3) addition of a category of health services provided by a nursing
21 home or residential psychiatric treatment center.
22 * **Sec. 4.** AS 18.07.111 is amended by adding a new paragraph to read:
23 (11) "nursing home" means a facility that is not used for acute care that
24 provides nursing care and related medical services 24 hours a day to individuals
25 admitted to the home because of illness, disease, or physical infirmity.
26 * **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to
27 read:
28 APPLICABILITY. Sections 1 - 3 of this Act apply to health care facilities, except for
29 nursing homes and residential psychiatric treatment centers, in existence or proposed on or
30 after the effective date of this Act. A decision of the Department of Health and Social
31 Services denying or granting a certificate of need that has been applied for or issued for a

1 health care facility, except for nursing homes and residential psychiatric treatment centers,
2 located in an area of the state other than in a borough with a population of not more than
3 25,000, the unorganized borough, or a community in which a facility has been designated as a
4 critical access hospital before the effective date of this Act shall be void and unnecessary. A
5 pending application for a certificate of need for a health care facility, except for nursing
6 homes and residential psychiatric treatment centers, located in an area of the state other than
7 in a borough with a population of not more than 25,000, the unorganized borough, or a
8 community in which a facility has been designated as a critical access hospital before the
9 effective date of this Act shall be returned to the applicant.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB287CS(HES)-DHSS-DBH-03-16-06
( ) Publish Date:

Revision Date/Time (Note if correction):

Dept. Affected: Health & Social Services

Title: LIMIT CERTIFICATE OF NEED TO BOROUGHS WITH A POPULATION OF LESS THAN 25,000

RDU: Behavioral Health

Component: Behavioral Hlth Medicaid Svcs

Sponsor: LYNN

Requester: HOUSE (HES)

Component No. 2660

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						26,724.4
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	26,724.4
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
1002 Federal Receipts						13,362.2
1003 GF Match						13,362.2
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	26,724.4

Estimate of any current year (FY2006) cost:

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

CS HB287 amends the certificate of need (CON) by exempting certain health facilities in the most populated areas from the program. The current CON program applies to all areas of the state (AS 18.07). This bill would require CON only to health facilities (other than nursing homes and residential psychiatric treatment centers) in the less populated areas of the state: (a) boroughs with a population of less than 25,000, (b) the unorganized borough, and (c) communities with a critical access hospital.

Continued

Prepared by: Janet Clarke, Assistant Commissioner
Phone 465-1630
Division: Finance & Mgmt Services
Date/Time 03/08/2006
Approved by: Karleen Jackson, Commissioner
Date 03/16/2006
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

FISCAL NOTE
FN #

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Alaska law requires that a person who plans to undertake certain activities related to a health care facility or to convert a facility to a nursing home must first demonstrate a need for the proposed service and obtain a certificate of need from the Department.

The CON program applies to these health care facilities: private, municipal, state or federal hospital, psychiatric hospital, skilled nursing facility, residential psychiatric treatment center, independent diagnostic testing facility, tuberculosis hospital, kidney disease treatment center, intermediate care facility, and ambulatory surgical facility. Excluded are the Alaska Pioneer Homes and Alaska Veterans Home and the offices of private physicians or dentists.

This bill would exempt facilities other than nursing homes and RPTCs in locations with population at or above 25,000 from the certificate of need requirement. It would eliminate the review of approximately 90%-95% of all certificates of need for the remaining health care facilities as almost all facilities are located in the exempt areas. Of the facilities currently subject to CON, 12 of the 25 hospitals/co-located nursing facilities, and all of the 9 ambulatory surgical centers, 3 independent diagnostic/testing facilities, 4 kidney dialysis centers, would be exempt under CS HB287. All of the 4 freestanding nursing facilities and 4 residential psychiatric treatment centers would still be subject to CON.

CS HB 287 would affect the 5 boroughs with population greater than 25,000: Municipality of Anchorage, Matanuska-Susitna Borough, Fairbanks North Star Borough, City and Borough of Juneau, and Kenai Peninsula Borough. Health care facilities and nursing home beds in these boroughs would not be subject to the CON process. Within the Kenai Borough, the community of Seward has a critical access hospital meaning that Seward is still covered by the CON program, but all other areas in the borough are not. Since the remainder of the state is either in a borough with a population less than 25,000 or is part of the unorganized borough the CON program would still be required in all other locations.

Based on interest expressed by health care providers and national trends the Department estimates that there are many projects in the exempt areas that would potentially start development immediately after the bill was passed. It is anticipated that construction on these facilities would peak within 3 years and that most, but not all, of the construction would be completed within 5 years.

In the Behavioral Health Medicaid component, the projects described below might be built if certain health facilties in the 5 largest boroughs are exempt from the CON program.

FISCAL NOTE
FN #

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION
Note that Residential Psychiatric Treatment Centers are not exempt under CS HB 287.

The fiscal note is based on a list of potential projects. It is not possible to identify with any confidence which projects would or would not have been approved anyway, although we know that some would. The department's best estimate is that approximately 30% of the projects would have successfully completed the CON process. **The fiscal note represents the aggregate Medicaid costs for the 70% of potential projects affected by CS HB 287 that likely would not have received a CON.**

The uncertainty stems from several reasons: some projects are for new services that we do not have experience with yet; the standards for CON were recently changed and we do not have enough experience yet to speculate; some projects would not submit an application because the provider was aware that they were unlikely to receive the CON.

Alcohol and Drug Hospital: A couple of years ago a 30-bed facility in Anchorage was discussed with Department staff. The cost is based on similar types of facilities and would be about the same as an RPTC facility except without all of the educational and gym facilities. This specialty hospital would be licensed as a psychiatric hospital but serve alcohol and drug clients. *Estimated annual cost to Medicaid: $16,607.5 starting in FY2012*

Psych Hospital Beds: Valley Hospital has an empty 40-bed acute care facility that they are looking to sell or lease. They have contacted the Department on at least 3 occasions regarding the conversion of the facility to a psych hospital. If Fairbanks became a regional center and CON was not required, 40-60 beds would likely be built, primarily for adolescents and children. Last year North Star submitted a CON proposing development of 30 inpatient psychiatric hospital beds for children in Fairbanks. They would likely have planned for more if it were not for CON. In addition, Providence had plans up until recently to build a 60-bed psych facility in Anchorage. Although this facility will not be built, someone else might consider building a facility of that size. The costs per bed were estimated from recent CON applications. *Estimated annual cost to Medicaid: $10,116.9 starting in FY2012 for a total of 90 beds.*

The GF match is based on the statutory SFY average FMAP for Title XIX for the appropriate year (2007-2008=57.58%; 2009=50.44%; 2010-2012=50.00%).

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB287CS(HES)-DHSS-DHCS-03-16-06
( ) Publish Date:

Revision Date/Time (Note if correction):

Dept. Affected: Health & Social Services

Title: LIMIT CERTIFICATE OF NEED TO BOROUGHS WITH A POPULATION OF LESS THAN 25,000

RDU: Health Care Services

Component: Medicaid Services

Sponsor: LYNN

Requester: HOUSE (HES)

Component No. 2077

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	2,373.5	4,747.0	7,142.4	14,546.6	16,195.1	18,942.7
Miscellaneous						
TOTAL OPERATING	**2,373.5**	**4,747.0**	**7,142.4**	**14,546.6**	**16,195.1**	**18,942.7**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
1002 Federal Receipts	1,366.7	2,733.3	3,602.6	7,273.3	8,097.6	9,471.4
1003 GF Match	1,006.8	2,013.7	3,539.8	7,273.3	8,097.5	9,471.3
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**2,373.5**	**4,747.0**	**7,142.4**	**14,546.6**	**16,195.1**	**18,942.7**

Estimate of any current year (FY2006) cost:

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal: [ ]

POSITIONS

Full-time						
Part-time						
Temporary						

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

CS HB287 amends the certificate of need (CON) by exempting certain health facilities in the most populated areas from the program. The current CON program applies to all areas of the state (AS 18.07). This bill would require CON only to health facilities (other than nursing homes and residential psychiatric treatment centers) in the less populated areas of the state: (a) boroughs with a population of less than 25,000, (b) the unorganized borough, and (c) communities with a critical access hospital.

Continued

Prepared by: Janet Clarke, Assistant Commissioner — Phone 465-1630
Division: Finance & Management Services — Date/Time 03/10/2006
Approved by: Karleen Jackson, Commissioner — Date 03/16/2006
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

FISCAL NOTE
FN #

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Alaska law requires that a person who plans to undertake certain activities related to a health care facility or to convert a facility to a nursing home must first demonstrate a need for the proposed service and obtain a certificate of need from the Department.

The CON program applies to these health care facilities: private, municipal, state or federal hospital, psychiatric hospital, skilled nursing facility, residential psychiatric treatment center, independent diagnostic testing facility, tuberculosis hospital, kidney disease treatment center, intermediate care facility, and ambulatory surgical facility. Excluded are the Alaska Pioneer Homes and Alaska Veterans Home and the offices of private physicians or dentists.

This bill would exempt facilities other than nursing homes and RPTCs in locations with population at or above 25,000 from the certificate of need requirement. It would eliminate the review of approximately 90%-95% of all certificates of need for the remaining health care facilities as almost all facilities are located in the exempt areas. Of the facilities currently subject to CON, 12 of the 25 hospitals co-located nursing facilities, and all of the 9 ambulatory surgical centers, 3 independent diagnostic/testing facilities, 4 kidney dialysis centers, would be exempt under HB287. All of the 4 freestanding nursing facilities and 4 residential psychiatric treatment centers would still be subject to CON.

CS HB 287 would affect the 5 boroughs with population greater than 25,000: Municipality of Anchorage, Matanuska-Susitna Borough, Fairbanks North Star Borough, City and Borough of Juneau, and Kenai Peninsula Borough. Health care facilities and nursing home beds in these boroughs would not be subject to the CON process. Within the Kenai Borough, the community of Seward has a critical access hospital meaning that Seward is still covered by the CON program, but all other areas in the borough are not. Since the remainder of the state is either in a borough with a population less than 25,000 or is part of the unorganized borough the CON program would still be required in all other locations.

Based on interest expressed by health care providers and national trends the Department estimates that there are many projects in the exempt areas that would potentially start development immediately after the bill was passed. It is anticipated that construction on these facilities would peak within 3 years and that most, but not all, of the construction would be completed within 5 years.

In the Health Care Services Medicaid component, the projects described below might be built if certain health facilties in the 5 largest boroughs are exempt from the CON program.

FISCAL NOTE
FN #

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

The fiscal note is based on a list of potential projects. It is not possible to identify with any confidence which projects would or would not have been approved anyway, although we know that some would. The department's best estimate is that approximately 30% of the projects would have successfully completed the CON process. **The fiscal note represents the aggregate Medicaid costs for the 70% of potential projects affected by CS HB 287 that likely would not have received a CON.** The cost estimates are conservative because, while all will have additional costs for Medicaid, for some of the facility types we were unable to quantify the cost.

The uncertainty stems from several reasons: some projects are for new services that we do not have experience with yet; the standards for CON were recently changed and we do not have enough experience yet to speculate; some projects would not submit an application because the provider was aware that they were unlikely to receive the CON.

Ambulatory Surgery Centers: Based on letters of intent, prior CONs that were denied or withdrawn, or request for information for surgery suites in a location. The cost is an average of recent surgery projects that submitted certificate of need applications. *Estimated annual cost to Medicaid: $2,196.7 by 2009 with 12 beds added in FY2007 and another 14 beds in FY2008 and FY2009, for a total of 40 beds.*

Cardiac Hospital: Although the Department has not received any specific inquiries for this type of service it is growing around the country and interest in Alaska may not be too far off. The cost was estimated based on an average cost of acute hospital beds in recent CON applications. *Estimated annual cost to Medicaid: $2,747.6 with 30 beds starting in FY2010.*

Cardiac Cath Labs: Four Labs are expected in the next 3 years. Fairbanks Memorial Hospital is considering one or two Labs now. It is expected that competition for labs in Anchorage and the Mat-Su Valley would develop and that Soldotna will want the service also. *Estimated annual cost to Medicaid is unknown.*

Independent Diagnostic and Testing Facilities: Additional competition would be expected in this area with 7 new facilities starting up in Juneau, Soldotna, Fairbanks, Mat-Su and Anchorage. Information received indicates Alaska Open Imaging has considered opening in Juneau and Providence Imaging in Wasilla. These projects would likely all be built in 1-2 years. *Estimated annual cost to Medicaid is unknown.*

FISCAL NOTE
FN #

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

General Acute Care Hospital: Providence has indicated a need for 50-100 beds and Valley Hospital has a partially completed space for 75 beds. Sold na and Fairbanks would be expected to add beds as well. The costs were estimated based on recent certificate of need applications. *Estimated annual cost to Medicaid: $8,242.8 by 2011 for 200 beds, with 40 new beds added in each of the next 5 years.*

Kidney Dialysis Centers: One new 16-station facility may be developed in Anchorage. We did have one contact requesting information on certificate of need for such a facility. *Estimated annual cost to Medicaid is unknown. Probably not started until FY2010.*

Long Term Acute Care Hospital Beds: This is a new service that was approved for Anchorage in 2005. There may be an interest in developing these same services in Fairbanks and the Mat-Su Valley. Long Term Acute Care hospitals are specialty hospitals, without emergency rooms or outpatient services, designed to provide extended medical and rehabilitative care for critically ill, medically complex patients who have multiple acute or chronic conditions. Most patients in these facilities are age 65 and over. Their length of stay is too long for acute care, but their medical condition is not right for long-term care, plus they have an opportunity for rehabilitation. These services will be paid for primarily through Medicare and Medicaid. *Estimated annual cost to Medicaid: $3,008.0 for 90 total beds starting in FY2010.*

Radiotherapy: Three programs are expected. Inquiries have been made for this type of facility in Wasilla and Fairbanks and a letter of intent for expansion was received a couple of years ago for expansion of radiotherapy in Anchorage. *Estimated annual cost to Medicaid is unknown. Probably not started until FY2010*

PET/CT Scanner: Fairbanks has indicated a continuing interest in this service even though a project was denied recently. A new one might be added in Anchorage. *Estimated annual cost to Medicaid is unknown. Probably started in FY2007.*

Orthopedic Hospital: Although none exists in Alaska, these specialty hospitals are growing rapidly in the rest of the US. It is only a matter of time before they move to Alaska. Costs were estimated to be similar to Cardiac Hospitals. *Estimated annual cost to Medicaid: $2,747.6 for 30 beds starting in FY2012.*

The GF match is based on the statutory SFY average FMAP for Title XIX for the appropriate year (2007-2008=57.58%; 2009=50.44%; 2010-2012=50.00%).

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

FRANK H. MURKOWSKI, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

April 13, 2006

The Honorable Bob Lynn
Representative District 31
State Capitol, Room 415
Juneau, Alaska 99811

Dear Representative Lynn:

The following information is provided in response to your letter of March 23, 2006 requesting information related to HB 287 and the Certificate of Need (CON) program.

- ***Would HB 287 cause an increase in the number of eligible Medicaid recipients? If so, how?***

HB 287 does not change the eligibility criteria for Medicaid enrollment; therefore it would not cause an increase in the number of persons eligible for Medicaid.

- ***Would HB 287 cause additional services to be offered which are not currently available to Medicaid recipients in Alaska?***

HB 287 would not add new services to the Medicaid program which are not already covered under the Medicaid State Plan. Most standard services covered are by now offered in-state.

- ***It is my understanding that, if services are not available in Alaska, Medicaid recipients will be sent to outside facilities to receive treatment. If people don't have to be flown out for treatment, wouldn't the cost be lower?***

Most out-of-state services are less costly on a per-day charge. If people receive treatment in Alaska instead of out-of-state, the cost would be higher. Medicaid pays for transportation to the lower 48 in cases where specialized care is not available in Alaska. If services which are not currently available to Medicaid recipients in Alaska become available in-state there may be some savings in transportation costs. The department estimates that nearly 18% of transportation costs are associated with the types of facilities affected by HB287; however, virtually all of that is in-state travel. Less than one half of one percent of transportation costs is to these types of facilities out-of-state. The savings opportunity is further limited because recipients from rural Alaska will still need transportation to urban areas to access the services. We estimate that between $38,000 and $76,000 of general fund dollars for transportation could be avoided."

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- ***Why would HB 287 cause services to be more expensive than what is charged by existing providers?***

HB 287 increases costs to Medicaid by increasing the rates paid for procedures. Medicaid payment rates for facilities are "...based on reasonable costs related to patient care..." (AS 47.07.070). This includes operations costs and capital costs. New facilities add additional capital and operating costs. If 25% of a facility's patient load is Medicaid, this statutory section requires Medicaid to pay rates that include 25% of the capital and operating costs. This share of new facility costs is a new cost to the Medicaid program.

As stated above, the number of eligible persons and services offered would not change under HB 287; and if we assume that the utilization rate of the services remains constant, then the number of procedures provided across all facilities would not change. With the same number of procedures divided between more facilities, a greater share of the capital and operating cost is distributed to fewer procedures, thereby increasing rates. One purpose of the CON program is to assure that there is sufficient demand for the services to minimize increased rates.

- ***According to the pricing worksheet you provided in your example of a fractured arm, both procedures were less expensive (more than 50% less) than the same procedure provided in a hospital setting. If these numbers are accurate, then would not HB 287 have a negative fiscal note indicating the savings to the State?***

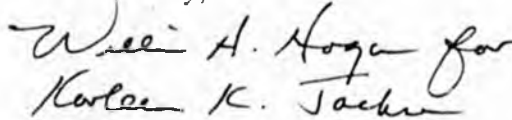
In the pricing worksheet we provided, the cost of treatment for a fractured arm was 53% lower in an ambulatory surgical center than in an outpatient hospital. The cost for an abdominal CAT scan example was 23% lower in an ambulatory surgical center than in an outpatient hospital. These examples were in response to a request for comparison of pricing methodologies. They are an accurate comparison of payments under current rates for a similar diagnosis treated in two different facility types for different patients, possibly with different circumstances and care needs. They are not a comparison of "before and after" HB287, therefore they do not indicate that HB287 should have a negative fiscal note.

- ***You claim that providing services in facilities that would qualify for the additional facility fees could cause Medicaid costs to go up, for example Medicaid subsidies such as the DISH payments to hospitals. But in your letter dated March 13, you indicated that the only facility you could imagine in this category would be a surgery center physically connected and adjunct to a hospital. So if none of the facilities would be paid more, how would this generate a higher fiscal note?***

It is possible that a new hospital or co-located facility could affect either total DSH payments made or DSH payments made to other hospitals if it has high uncovered uninsured care costs. If that happened, then the hospital's facility specific limit for DSH could increase, which could generate a higher fiscal note. An increase in facility specific limit does not automatically mean additional DSH payments. Hospitals participating in the DSH program must also meet eligibility requirements and agree to perform necessary health and social services through an approved project. DSH payments are subject to the availability of matching funds and the continued allotment of federal financial participation.

If you have questions concerning this information, please fee free to contact either Tony Lombardo at 465-3030 or Janet Clarke at 465-1630.

Sincerely,



Karleen K. Jackson, Ph.D.
Commissioner

cc: Anthony Lombardo, Deputy Commissioner
Janet Clarke, Assistant Commissioner
Sherry Hill, Special Assistant
Elmer Lindstrom, Special Assistant
Laura Baker, Budget Chief
Jack Nielsen, Office of Rate Review
David Pierce, CON Program

Click here to return to the original story

My Turn: State attacks bill with inflated cost estimates

Sponsor: Repealing Certificate of Need law encourages competition

Want to open a health care business in Alaska? Under current law, you'll have to go hat-in-hand to the governor and his minions to beg for a "Certificate of Need." That's why I've sponsored House Bill 287, and co-sponsored an initiative to repeal the Alaska Certificate of Need law. If someone wants to open a hot dog stand, shoe store, or a health care facility, it's none of the government's business.

A competitive marketplace is as American as apple pie, whether for medical care or anything else. Competition encourages lower prices, motivates excellence, and facilitates consumer choice. That's Economics 101. Current Certificate of Need requirements discriminate against small businesses by denying entry into the health care market. Limited choices inflate prices. Perhaps the Certificate of Need should be relabeled "Certificate of Monopoly."

When I get sick, I don't want the government limiting my choices. The more medical availability the better. When I shop for a new TV, things usually turn out better if I have a wide range of dealers and models to choose from. Good medical care is no different, and is infinitely more important.

Medical costs in Alaska are skyrocketing to crisis levels. Eliminating Certificate of Need requirements should help lower Alaska's health care costs, reduce Workers' Compensation costs, and help keep things more affordable for both families and businesses. We can't lower the price of gasoline by limiting oil production. Why would limiting the supply of medical facilities lower health care costs?

As expected, health care monopolies with vested interests have responded the only way they can - by attaching humongous fiscal notes to both my bill and the initiative. To paraphrase Ronald Reagan, "There they go again!"

The first cost scenario for the initiative eliminating the Certificate of Need was an amazing $41 million. Fiscal notes by the Department of Health and Social Services estimated the bill would cost the state about $45 million.

Recently a newspaper opinion piece by the administration pegged the fiscal impact at more than $30 million. Trying to get realistic estimates from the administration has been like trying to pick up a bar of soap in the shower. News flash! Fiscal notes for any proposed legislation should be based on clearly substantiated and verifiable data. Anything else is disingenuous.

Experts believe the astronomical figures attached to the bill are grossly misleading and inaccurate.

1) Estimates are based on extremely unlikely expenditures, like the cost of a new cardiac hospital. That's as likely as Lockheed building an aircraft factory here.

2) The administration makes projections for new facilities without demonstrating interest or need (see cardiac hospital above).

3) Most expenditures cited in the administration estimates are paid for by the business owners, at no cost to the state (for example, ambulatory surgery centers, independent diagnostic facilities, etc.) - nonetheless they're lumped into the fiscal note.

4) Statistics aren't verifiable. No explanation accompanying the data - just numbers changing with each phase of the moon. The state admits the cost estimates are suspect by stating, "It is not possible to identify with any confidence which projects would or would not have been approved." So the state just includes all of them.

5) Fiscal notes don't even mention potential savings to the state if the Certificate of Need requirement is scrapped.

The goal of my bill and the related initiative is to eliminate obsolete and artificial Certificate of Need barriers, thereby allowing expanded medical choice and less expensive health care. My Bill and the initiative should be judged on verifiable fiscal information, potential cost savings and excellence for all concerned. That's only fair. Like everything else, medical care should be based on the principles of free enterprise - not political influence from large monopolistic hospitals.

• State Rep. Bob Lynn, R-Anchorage, is sponsor of House Bill 287.

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Nancy Manly

From: Jermey Hayes jhayes@admin.apcak.net]
Sent: Thursday, March 30, 2006 2:30 PM
To: Nancy Manly; Rep. Bob Lynn; Rep. John Coghill; Rep. Vic Kohring; Rep. Mike Chenault
Subject: HESS- Requested Studies from HB 287 Hearing
Attachments: Conover & Sloan - Does Removing Certificate of Need Regulations Lead to a Surge in Health Care Spending.pdf; Washington Policy Center . Publications.mht

Representatives—

Here are the studies that were requested from me at the HB 287 hearing Tuesday. I hope these prove useful. Thank you for your time, and have a great day!

Jeremy Hayes
Assistant Administrator
Advanced Medical Centers of Alaska

Pain Management - Sports Medicine & Rehab - Health Psychology

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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 high.

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

	Beds per 1,000 Population	Intensity: Expense per Adjusted Patient Day	Intensity: 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

Major Impact	Number of Studies Showing:		
	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.

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Policy Brief

Failure of Government Central Planning
Washington's Medical Certificate of Need Program

by John Barnes, Policy Analyst
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I. Introduction

Imagine your community is home to a nursing care facility that has operated for years with optimal customer satisfaction. It provides quality care and assistance, its facilities are modern and clean, and the staff is excellent. The nursing home is exceeding capacity and its operators look at the growing demand and decide to expand the facility by adding five beds. They consult their experts, study options and projections, and, after careful consideration secure a building permit and begin construction. Sounds reasonable, right? Well, they just broke the law.

Washington is one of thirty-seven states (including the District of Columbia) that require government permission to open or expand most kinds of health care facilities. In addition to the usual building permits and zoning approval, the state must grant a Certificate of Need (CON) before such facilities can be built, expanded or modified significantly. The 14 states that do not have CON laws include large states like California, Pennsylvania, and Texas, and together comprise about 35% of the U.S. population (a full list appears on page 8). *[1]*

Washington's Certificate of Need law applies only to providers of health care. It functions as a control valve to limit the supply of health care. Hospital and clinic managers must comply with a complicated set of established procedures and formulas to prove to state bureaucrats that there is or will be a need for whatever service they seek to provide. Without successfully navigating the CON process, it is illegal to offer new health care services to Washington residents

> *Federal lawmakers proposed solving a problem created by government intervention by imposing more government intervention*

Public policy in Washington should focus on assuring access to affordable, high quality health care for all the people of our state. The Certificate of Need program fails to advance this fundamental goal. This study describes the history of the Certificate of Need concept, summarizes how the Washington law works, compares its stated goals with actual performance, and presents practical policy recommendations for improving access to affordable health care for the people of Washington.

II. Background

Origins of Certificate of Need

The roots of the Certificate of Need idea date back to 1964 in Rochester, New York. Local businesses and Blue Cross established a community health planning council composed of consumers, insurers and health care providers to study the need for hospital beds. The group decided there was a surplus and recommended that the state restrict supply in order to prevent what was then considered too many health care facilities. This effort culminated in New York's passage of the nation's first Certificate of Need law in 1966. *[2]*

Federal Certificate of Need Law

Also in 1966, Congress enacted the Comprehensive Health Planning Act. States receiving federal funds under public health and social security programs were required to establish local and state health planning agencies. Those states that already had planning agencies were required to expand the reach and authority of these departments.

In 1972 the federal government amended the Social Security Act to compel all states to review health care capital expenditures in excess of $100,000. Failure to comply meant a state would be denied Medicare and Medicaid reimbursements for capital expenditures. *[3]* This provision served as the skeletal beginnings of a national Certificate of Need law. *[4]*

In 1974, during a time when many lawmakers were pushing for a complete government takeover of the health care system, Congress passed the National Health Planning and Resources Development Act (NHPRDA). *[5]*

The NHPRDA law directed each state to examine proposed health care facilities and "make findings as to the need for such services." *[6]* If the states did not comply with the Act's directives, the federal government would withhold funding. *[7]* This created strong incentives for states to implement far-reaching health care planning regulations

The NHPRDA law recognized that "the massive infusion of Federal funds into the existing health care system" had severely distorted the health care market by "contribut[ing] to inflationary increases in the cost of health care." *[8]* Ironically, federal lawmakers proposed solving a problem created by government intervention by imposing more government intervention.

Distortions Created by Cost-Based Reimbursement

At that time, health care was built on a cost based reimbursement system. Price-based competition had little, if any, role in health care because providers were able to recover full cost from Medicare and Medicaid, no matter how high. The system provided little incentive for cost reduction. "There are presently inadequate incentives for the use of appropriate levels of health care," lawmakers said. *[9]* They believed that excess facility supply led to increased costs of business, and that those increased costs would be passed on to patients. They intended top-down health planning and strict Certificate of Need laws to constrain supply and therefore control prices.

Along with price inflation, federal lawmakers believed that a market distorted by the infusion of federal tax dollars led to poor

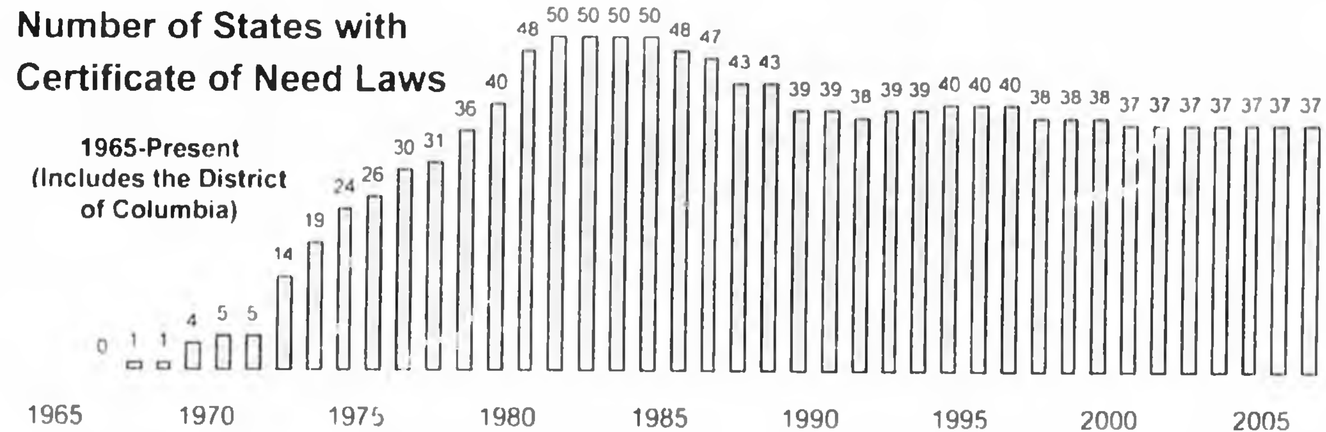
distribution of health care facilities. Thus another purpose of early health planning and Certificate of Need laws was to control the geographic distribution of health care. Lawmakers believed that "one efficient and fully-utilized piece of equipment was better than two that were under-utilized." *[10]*

In the years following the passage of the NHPRDA, states began adopting Certificate of Need laws. The primary goal of these laws was to contain rising health care costs. Eventually every state and the District of Columbia adopted Certificate of Need regulations.

Repeal of Federal Law

In 1982, the federal government acknowledged the failure of its Certificate of Need law to reduce health care costs and repealed the mandatory health planning law. *[11]* In the years following federal repeal, 14 states eliminated their medical facility control laws as well. Thirty-six states and the District of Columbia retained their Certificate of Need laws. Washington is one of these. Figure 1 shows the number of states having Certificate of Need laws from 1966 to today. *[12]*

Figure 1



III. Overview of Washington's Certificate of Need Program

Washington imposed its first Certificate of Need requirements in 1971. *[13]* Later the program was changed to adapt to the requirements of the 1972 Social Security Act amendments and the 1974 NHPRDA law. With these early adjustments, the program as created in the 1970s remains in force today.

The Certificate of Need program forms the backbone of centralized health planning in the state. The five stated purposes of

health planning are: [14]

- "To promote, maintain, and assure the health of all citizens in the state, to provide accessible health services, health manpower, health facilities, and other resources while controlling excessive increases in costs, and to recognize prevention as a high priority in health programs, as essential to the health, safety, and welfare of the people of the state."

- "That the development of health services and resources, including the construction, modernization, and conversion of health facilities, should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation."

- "That the development and maintenance of adequate health care information, statistics and projections of need for health facilities and services is essential to effective health planning and resources development."

- "That the development of nonregulatory approaches to health care cost containment should be considered, including the strengthening of price competition."

- "That health planning should be concerned with public health and health care financing, access, and quality, recognizing their close interrelationship and emphasizing cost control of health services, including cost-effectiveness and cost-benefit analysis."

The Certificate of Need program is administered by the state Department of Health. Between 1971 and July 2005, the state made decisions on [illegible],786 applications for Certificate of Need. Of those decisions, 177 applicants were denied permission to provide new medical services. Two Certificates of Need were rescinded after the Department's decision to grant was overturned on appeal. [15]

Washington Compared to Other States

Washington has one of the most stringent Certificate of Need laws in the country. Fourteen states have no Certificate of Need restrictions on building new medical facilities, while 36 states and the District of Columbia have such programs in place.

The scope of Certificate of Need laws varies from state to state. Some are highly detailed. In Alabama, for example, hospital managers must obtain a Certificate of Need before purchasing a new ultrasound machine. Connecticut requires state approval before a health care office can buy certain computer equipment. [16] Other states, such as Louisiana and Nebraska, apply their Certificate of Need law to only one or two types of service, leaving health care managers free to make all other decisions without the health department's prior approval.

Comparing state Certificate of Need programs is no easy task. Certain regulated medical services are more common or are more expensive than others. For example, one state might cover more medical services that are rare, like organ transplants, while another covers fewer services, such as CT scans, that are central to the health care infrastructure and affect more patients.

Figure 2 shows a comparison of Certificate of Need requirements in the fifty states and the District of Columbia. The comparison gives each state a weighted ranking, with higher numbers representing larger regulatory burdens. Under this method, Connecticut ranks the highest. Its law covers 24 services and expenditures, earning a rank of 28.8. Alaska is next highest - it covers 26 services and expenditures, but collectively these have less scope, earning a rank of 26. The last fourteen states in Figure 2 are ranked zero because they have no Certificate of Need laws.

Washington is the 18th most regulated in the country, with a weighted ranking of 12.8. Washington's Certificate of Need law covers 16 different health care services and expenditures. Washington's number 18 ranking represents a higher level of regulation than may appear at first, for two reasons. First, almost two-thirds of the states have a lower level of regulation than Washington. Second, the rating method takes into account the scope of a state's regulatory burden, in addition to its place on the list. For example, Washington ranks only six places up the list from Iowa, but its weighted level of regulation is twice as high.

Washington's Certificate of Need law covers 16 important health care services, making the state one of the most heavily regulated in the nation.

Figure 2 (Available in pdf)

IV. Description of the Project

What Washington Law Covers

As reflected by its high national ranking, Washington's Certificate of Need law is very broad. It covers every major kind of health care facility and most major health services *[17]* Without prior state approval, it is illegal in Washington for any person to:

- Construct, establish or develop a health care facility, including;
    - Hospitals
    - Kidney disease treatment centers (dislysis)
    - Psychiatric hospitals
    - Ambulatory surgical facilities
    - Nursing homes
    - Hospices
    - Certain continuing care retirement communities
    - Home health agencies

- Sell, purchase or lease part or all of any existing licensed hospital, regardless of profit or non-profit status;
- Increase the number of kidney dialysis treatment stations;
- Increase the number of hospital beds available to patients, or redistribute the number of existing beds among acute care, nursing home care and boarding home care;
- Make any improvement to a nursing home that exceeds two million dollars;
- Replace an existing nursing home with a new one;
- "Bank" beds at a nursing home, that is, set aside some beds to reduce the home's total number of regulated beds;
- Establish a new tertiary health service offered by a health care facility that was not offered by that health care facility within the 12-month period prior to the time the facility will offer the services. Tertiary health services include:
  - Specialty burn services
  - Intermediate care nursery
  - Neonatal intensive care
  - Transplantation of solid organs
  - Open heart surgery
  - Inpatient physical rehabilitation, Level I for persons with nonreversible multiple function impairments of moderate-to-severe complexity
  - Specialized inpatient rehabilitation services.

Washington's Certificate of Need law leaves few stones unturned. State lawmakers have placed all but a handful of medical services under the Certificate of Need umbrella. The exceptions include narrow services like air ambulance services, business computers and diagnostic imaging.

Washington's Certificate of Need law leaves few stones unturned, with all but a handful of medical services being subject to Certificate of Need requirements.

Timelines in the Process

The Certificate of Need law is costly and time consuming. It includes a number of timelines intended to serve as a chronological framework for the process. *[18]* In practice, however, these deadlines mean little, since they are seldom met. Figures 3 through 6 show the required timelines.

Figure 3

Number of Days	Regulatory Action
0	File a letter of intent with the Department of Health
30	File application for Certificate of Need
45	Department of Health screening period (15 working days)
90	Deadline for responding to screening questions (up to 45 days)
95	Notification of beginning of review (5 working days)
130	End of public comment period (35 days)
140	End of rebuttal period (10 days)
185	Department of Health decision date (final review period: 45 days)
Total Time for Regular Review: Approximately 6 Months	

There is also a timeline for an expedited review process. *[19]* If a business or organization is acquiring an existing health care facility, they fall into this category. Expedited reviews also include predevelopment expenditures and projects intended to correct deficiencies such as safety hazards or state licensing requirements. Figure 4 shows the expedited review timeline.

Figure 4

Number of Days	Regulatory Action
0	File a letter of intent with the Department of Health
30	File application for Certificate of Need
45	Department of Health screening period (15 working days)
90	Deadline for responding to screening questions (up to 45 days)
95	Notification of beginning of review (5 working days)
115	End of public comment period (20 days)
125	End of rebuttal period (10 days)
145	Department of Health decision date (final review period: 20 days)
Total Time for Expedited Review: Approximately 5 Months	

If the Department of Health denies a Certificate of Need, the applicant can ask for interim reconsideration. *[20]* If the Department of Health upholds its denial of a Certificate, the appeal process can begin. The first step is the Administrative Appeal, which takes the form of an adjudicative proceeding. *[21]* Figure 5 shows the timeline for the Administrative Appeal.

Figure 5

Time	Regulatory Action
	1. File application for adjudicative p oceeding (deadline: within 30 days after Department of Health decision)
20 days	2. Administrative Law Judge* issues scheduling order and notice of hearing
4 to 5 months	3. Hearing before Administrative Law Judge
1 to 2 months	4. Post-hearing breifs submitted
1 to 2 months	5. Administrative Law Judge issues decision
Total Time for Adjudicative Proceeding: 7 to 10 Months	

* The Administrative Law Judge is an employee of the Department of Health whose role is to determine whether the Department's denial of a Certificate was made in accordance with the applicable statutes and regulations.

If the Administrative Appeal upholds the Department of Health's decision to deny a Certificate of Need, the applicant may then proceed to Judicial Review. The Judicial Review process is an appeal to Superior Court. Figure 6 shows the timeline

Figure 6

Time	Regulatory Action
	1. File Petition for Judicial Review in Superior Court (deadline: within 30 days after Administrative Law Judge decision)
6 to 10 Months	2. Trial (oral argument based on administrative record; no new evidence)
1 to 2 Months	. Superior Court issues decision

Total Time for Judicial Appeal: 7 to 10 Months

Total Potential Time for Certificate of Need Process: 2+ Years

The Judicial Review can reverse the Department of Health's decision and issue a Certificate of Need. If that happens, then the project may begin. If the Judicial Review upholds the denial, then no Certificate of Need will be issued and the intended project cannot commence. The total potential time for the Certificate of Need Process is more than two years.

Other Factors in the CON Decision

There is much more to the process than a mere timeline. The process for acquiring a Certificate of Need depends largely on the kind of project involved. The flow chart in Figure 7 (available in pdf), at the center of this Policy Brief, shows the process required for opening a new surgery operating room.

Ambulatory surgical centers are outpatient surgery facilities that use a doctor's office environment for minor surgeries that do not require overnight stays in a hospital. These centers began appearing in the early 1970s as a way to reduce the overhead cost of conducting simple, low risk treatments. Today there are about 4,600 centers nationally, a 53% increase over the number operating just five years ago. *[22]* The state Department of Health has developed a complicated formula for analyzing the perceived need for such centers in Washington.

The Department of Health uses numerous criteria for making this determination. At their core is a numeric formula that uses current and projected changes in population and medical capacity to calculate "net need." *[23]*

Other factors influence the decision as well. The Department of Health, not the marketplace, determines whether or not a proposed project is financially feasible and whether or not the project will, "foster containment of the costs of health care." *[24]* The Administrative Code outlines 31 criteria and sub-criteria that state managers use to decide on the need for a proposed health care facility or service. *[25]* Those criteria include:

- " The applicant's past performance in meeting obligations under any applicable federal regulations requiring provision of charity care.
- " The existence of any civil rights complaints against the applicant.
- " The effect of the reduction, elimination, or relocation of a health service on the ability of low-income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups and the elderly to obtain needed care.
- " The likelihood that all residents of the area, including low income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups and the elderly will have access to the proposed health service.

- " That the proposed project will not have an adverse effect on health professional schools and training programs.

The criteria are much the same if an applicant proposes to build a hospital. The key difference is an additional formula to calculate the number of hospital beds. Figure 8 shows this process. *[26]* This complicated formula, drafted in 1979 and still in use today, is based on a methodology outlined in Section 4 of the State Health Plan. Section 4 alone is over 40 pages in length.

Figure 8 (Available in pdf)

V. Review of the Effectiveness of Certificate of Need

The Certificate of Need law is intended to restrain costs and increase access to health care. The process actually has the opposite effect. By forcing anyone interested in building or expanding health care facilities to maneuver through an arcane maze of bureaucratic regulations, the state makes it harder to provide modern, flexible, community responsive health care. This section reviews the Certificate of Need program and assesses its effectiveness based on its stated goals.

The Basic Reasoning behind the CON Law Is Faulty

The chief argument proponents use to justify the Certificate of Need law is that surplus capacity in health care facilities leads to duplication of services and increased operating costs These higher costs, they say, are then passed on to insurance companies and patients in the form of higher prices. By regulating the supply, surplus will be avoided. Health care is an "essential of life," planning advocates say, and the market is incapable of producing the necessary supply of hospital beds on its own. The reasoning behind this justification is faulty for two reasons.

First, the realities of the economy make no distinction between things deemed "essentials of life" and any other product or service. The harmful impact of over-regulation on both is the same. Health care is no different than any other product or service in our economy and the same dynamic market forces determine the quality, availability and price of it. In fact, the more essential a product or service is to meeting basic human needs, the more important it is for policymakers not to place artificial restraints on it.

Second, the "essentials of life" argument for regulating health care overlooks the even more fundamental needs of life that are bountifully provided through vigorous competition in the free market Food, clothing, housing and transportation are vital and immediate human needs. For the vast majority of Washington residents these needs are met through a vibrant system of private buying and selling. In these cases the government's role is properly limited to protecting public safety, enforcing voluntary contracts and ass[illegible] the needy. Everyday experience shows that when the market is free to operate under minimal government oversight, the result is abundance, quality service and low price.

The more health care providers, consumers, and insurers are permitted to communicate freely in a normally functioning marketplace, using advertising, price signals and other means, the more society will be able to provide sufficient affordable health services to meet essential human needs. The rapid growth of Health Savings Accounts and consumer directed health plans is an indication of this trend The Certificate of Need law works in the opposite direction, blocking fast and accurate communication between patients and health care providers, and preventing providers from responding to changing needs in the community.

Certificate of Need Laws Do Not Save Money

The assertion that Certificate of Need laws save money is further refuted by a number of recent studies. In July 2004, the Federal Trade Commission and the Department of Justice found that, "the reason that CON has been ineffective in controlling costs is that the programs do not put a stop to 'supposedly unnecessary expenditures' but merely 'redirect any such expenditures into other areas.'" *[27]*

In 1999, the Washington State Joint Legislative Audit and Review Committee (JLARC) reviewed the Certificate of Need law. JLARC found that the Certificate of Need law has not had any clear success in meeting its legislative goals. Its report, titled "Effects of Certificate of Need and Its Possible Repeal," reached several conclusions:

> "The study found that CON has not controlled overall health care spending or hospital costs. The study found conflicting or limited evidence about the effects of CON on the quality and availability of other health care services or about the effects of repealing CON." *[28]*

The study went on to assess the effectiveness of the CON law in terms of cost, quality and access.

Cost:

- " The weight of the research evidence shows that CON has not restrained overall per capita health care spending. *[29]*

- " Numerous studies have shown that CON has not controlled overall hospital spending. One study found that CON actually increased hospital expenditures.

Quality:

- " Certificate of Need concentrates volume, and the research evidence is strong that higher volumes of certain surgical procedures can lead to better outcomes. *[30]*

- " CON has a mixed record in concentrating volume. For example, studies show that CON was not effective in Ohio and Delaware in increasing volume, but did concentrate volume for some services in Pennsylvania. *[31]*

Access:

- " Washington's CON law has had no effect on improving access *[32]*

- " In some instances, CON rules are used to restrict access by preventing the development of new facilities. *[33]*

CON Laws Do Not Increase Access

In King County there are 120 retirement communities, but only twelve are tied to nursing homes. Almost all operating nursing homes are 30 to 40 years old. *[34]* Waiting lists are common at even mediocre facilities. Due to Certificate of Need restrictions and other state-imposed regulations, additional nursing homes are not being added as the population ages. Under normal market conditions, the supply of elder care would increase as the need increases. The burden of the CON law disrupts this natural development.

In addition to limited access, those seeking nursing home care face high costs, even though the Certificate of Need framework is intended to reduce costs. Continuing care retirement communities tied to nursing homes require monthly payments along with large up-front fees, which can range from $270,000 to $400,000, and are simply beyond the reach of most people. *[35]* The situation indicates that the Certificate of Need law has not been effective in easing the rising burden of medical expenses for the elderly.

Studies throughout the U.S. have arrived at similar conclusions: the data indicate that a program designed to reduce cost, improve quality and promote access has not achieved any of these goals. *[36]* In addition, the 14 states with no Certificate of Need laws, which are home to more than one in three Americans, show no significantly higher rate of health care spending due to the lack of such laws.

Assessing Promise and Performance:
The Certificate of Need law has not met its stated goals
(All quotes are from Revised Code of Washington 70.38.015)

The crafters of Washington's health planning and Certificate of Needs law had clear goals in mind. Thirty years later, it is possible to assess the law's success or failure in meeting its goals. A clear pattern emerges. Washington's Certificate of Need process has not achieved what the authorizing law promised.

What the law promised: Health planning "should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation."

The situation today: A quick glance at the Certificate of Need procedure for surgery operating rooms (see figure 7) reveals a process that is anything but orderly. Moreover, health care providers seeking permission to build would hardly use the word "planned" to describe the process and its results. For those who must submit to it, the Certificate of Need process is expensive, inconsistent and unpredictable.

What the law promised: "The development of nonregulatory approaches to health care cost containment should be considered."

The situation today: There is far more regulation of health care today than when the CON law was enacted. State law now imposes 49 separate mandates on every health insurance policy sold in Washington. Hospitals, clinics and doctors must comply daily with stacks of complicated regulations

that inhibit the practice of medicine. Under CON, the state alone decides what health care facilities are allowed and where they will be built.

What the law promised: "Price competition should be strengthened."

The situation today: There is far less price competition in health care today than there was when the CON law passed. Patients and providers are generally unaware of health care pricing and usually have no idea how much a particular treatment costs. The CON law directly stifles price competition by discouraging existing providers from offering new services, and by blocking new competitors from entering the marketplace.

What the law promised: "Health planning should be concerned with public health care financing, access, quality emphasizing cost control of health services."

The situation today: The CON law has failed to control health care costs. In recent years the cost of health coverage has increased up to five times faster than inflation. The CON law has also failed to increase access to health care. In western Kittitas County, for example, one ambulance and one paramedic provide service for an area of some 800 square miles. *[37]*

Certificate of Need Suppresses Competition and Creates Monopolies

Certificate of Need appeals are a legal mechanism that health care organizations and facilities use to fend off competition. A review of the Certificate of Need action log dating from 1971 to July 2005 reveals that the issuance of a Certificate of Need is often appealed by one or more medical businesses that perceive an economic threat if a new medical facility opens in their area.

When the Department of Health granted Swedish Health Services permission to build an ambulatory surgery center in Bellevue, Overlake and Evergreen medical centers asked the Department to reconsider on the grounds that Swedish's plans would intrude upon their health planning area. The Department upheld its original decision, so Overlake and Evergreen then filed an appeal. The adjudicative hearing resulted in Swedish losing the Certificate of Need.

The Bellevue situation is not an isolated incident, this happens on a regular basis. Easy appeal is built in to the Certificate of Need process. No reasoning or criteria is required for "affected parties" to request a hearing and appeal a decision. *[38]* Appeals center on the cryptic minutia of the way state employees interpreted the rules, contesting, for example, the method of regression analysis, the identification of service areas, and the definitions used to determine price competition and patient choice. *[39]*

The Certificate of Need process functions as

The Certificate of Need process functions as protection for monopolies, insulating businesses that are already in the market and keeping competitors from entering. Anti-competitive activities that would be severely punished by federal anti-trust laws if attempted by other private companies are sanctioned

protection for monopolies, protecting businesses already in the market while keeping competitors from entering.

and promoted by the state when they involve medical providers.

Even when established health care organizations are unable to prevent competitors from entering their area, they usually succeed in using the Certificate of Need appeals system to block market entry to new providers for significant amounts of time, often years.

A 2004 study by the Federal Trade Commis on and the Justice Department reported that:

> "...where CON programs are intended to control health care costs, there is considerable evidence that they can actually drive up prices by fostering anticompetitive barriers to entry." *[40]*

The same study found that the Certificate of Need process:

> "has the effect of shielding incumbent health care providers from new entrants. As a result, CON programs may actually increase health care costs, as supply is simply depressed below competitive levels." *[41]*

Increasingly, hospitals are facing competition from ambulatory surgery centers, which offer minor surgical procedures that do not req jire an overnight stay. Often times these facilities offer the same surgery as a hospital but at lower prices. It is one of the ways the market is adjusting to make health care delivery more efficient and cost effective. Established hospitals, however, use the Certificate of Need law to prevent ambulatory surgery centers from opening in their service areas, thus blocking access to health care choice and lower costs for consumers.

The 1974 national health planning law (NHPRDA) itself noted the need for incentives to develop more economical ways of treating minor surgery patients without formal admission into a hospital. Ironically, the very laws designed to foster alternatives to expensive hospital stays are today used against innovative providers who are trying to offer those very alternatives

Discouraging Public Debate

Fear of endangering their prospects for success prevents many applicants from publicly questioning or debating the process. When asked about the state refusing to issue his company a Certificate of Need, Bill Wolverton of Renal Care Group said "I'm not going to be able to speak for the record; we're about to start an appeals process." *[42]*

"I'm not going to be able to speak for the record; we're about to start an appeals process," remarked Bill Wolverton of Renal Care Group

Representatives of other organizations have expressed similar sentiments about applications and appeals in the pipeline. During testimony before the Senate Health and Long-Term Care Committee on a bill calling for a study of the Certificate of Need program, one expert said, "Certificate of Need applications have become much more of a political struggle than they should be." *[43]* Applicants are equally reluctant to appear critical of the process or departmental staff.

VI. Problems and Delays in Certificate of Need Review

The foregoing section examined the basic weaknesses in the Certificate of Need law. Research shows the law is not fulfilling its goals because the concept on which it is based, top-down limits on health services through state central planning, is fundamentally unsound. A review of the law as implemented in practice indicates the process suffers from other shortcomings as well, primarily added delays and complications in the process of gaining state approval for a project. Even if the problems discussed below were addressed, however, the foundational defects in the Certificate of Need idea would remain.

CON Process Exceeds Legal Timelines

In May 2005, the Department of Health denied permission to Swedish Medical Center and Overlake Hospital Medical Center to build new hospitals in Issaquah. This decision was the culmination of a regulatory tug-of-war that had been going on quietly since the two hospitals submitted their plans to the state more than a year before. *[44]* This does not include the six months Swedish and Overlake spent developing the proposal in the first place.

A review process that was supposed to provide expedited review and include public input did neither. *[45]* After more than a year of paperwork, lengthy meetings and countless staff hours, officials at Swedish and Overlake ended up right back where they started, and the people of Issaquah were deprived of new medical services that two respected and established hospitals were eager to provide

Figure 9 shows the timeline for the Issaquah hospital decision process. *[46]* Compare this with the statutory timeline shown in Figure 3. What should have taken just over six months actually took more than thirteen months.

Figure 9

Timeline for Proposed Issaquah Hospital	
Date	**Action**
April 6, 2004	Letter of intent submitted
July 21, 2004	Applications submitted
July 22, 2004 - Feb. 6, 2005	Certificate of Need office's pre-review activities (application screening / public comments begin)
Feb. 7, 2005	Certificate of Need office begins review of applications
March 7, 2005	Public hearing conducted / end of public comment
March 25, 2005	Rebuttle documents submitted to Certificate of Need office
May 10, 2005	Certificate of Need office makes decision, does not issue Certificate of Need to Swedish or Overlake

Total Time for Application Process: 13 months

The Issaquah case is not a lone example. A sampling of recent Certificate of Need application timelines, shown in figure 10, reveals that the process typically takes much longer than the law says it should. In these cases, the office handling Certificate of Need requests delayed giving answers by an average of 60% beyond the time required by law.

Figure 10

Project	CON Process Should have Taken:	Actually Took:
Sale of Providence Yakima Medical Center to Heatlh Management	5 months	8 months
Semper-Care establishing long-term acute care hospital in Spokane	6 months	9 months
Franciscan Health System establishing an ambulatory surgery center in Gig Harbor	6 months	9 months
Hospital Proposal in Gig Harbor	6 months	11 months
Average Delay		**3.5 months**

CON Process Takes Longer than Planned Construction

The time for securing a Certificate of Need usually exceeds the time it takes to actually build the proposed medical facility. For example, in May 2003 the state granted Swedish Heal*h Services permission to build an ambulatory surgery center in Bellevue. The process required six months for initial planning and eight months for Certificate of Need approval.

So far, Swedish has spent three years processing Certificate of Need paperwork, for a facility that would take only 15 months to build

Swedish's competitors, Overlake and Evergreen medical centers, immediately appealed the Certificate of Need issuance. Tod. y, more than two years after the state gave Swedish the go-ahead to begin construction, the project remains in limbo. The process dragged on so long that Swedish lost its lease option on the building it planned to convert to into the new surgery center. So far Swedish has spent three years processing Certificate of Need paperwork for a facility that, if approved, would ' ke only fifteen months to complete. In the meantime, thousands of surgery patients who would have benefited from the new facility have been forced to go elsewhere or do without.

Community Input Is Often Ignored

Defenders of the Certificate of Need programs call it a "flexible tool" that "helps protect the critical health care infrastructure" by means of "community based planning." *[47]* There is no objective evidence, however, that Certificate of Need decisions

include community feedback.

The recent battle over the proposed hospital in Issaquah serves as a case in point. On March 7, 2005, the Department of Health held a public hearing in Issaquah for the community to voice its concern about Swedish and Overlake's desire to build a hospital in their area. More than five hundred people attended, many of them physicians. The real debate among participants was not whether or not there should be a hospital - only eleven people said the community did not need a new hospital - but rather who should build it, Swedish or Overlake.

The views of the vast majority of people who attended the public meeting had no effect on the final decision.

[48] As we know, the Department of Health denied both applications. The views of the vast majority of people who attended the public meeting had no effect on the final decision.

In contrast to the Issaquah case, consider what happened in Gig Harbor. Franciscan Health System proposed building a 112-bed hospital there, and in May 2004 the Department of Health announced its approval of an eighty-bed hospital. In announcing its decision, the Department of Health said, "public input overwhelmingly supported a hospital in Gig Harbor, and that public sentiment was substantiated in the fact-based analysis." *[49]*

Comparing what happened in Issaquah with Gig Harbor demonstrates that the public's view only matters when agrees with the state's "fact-based analysis." Public input only seems to be relevant when it supports the pre-set designs of the planning process, and is ignored when it contradicts the regulatory formulas.

VII. Examining Arguments Made in Support of Certificate of Need

Advocates of Certificate of Need make a number of arguments to defend their views, and cite a number of states where they say it is working as intended. On closer examination, however, the evidence cited typically relies on a narrow set of data to back up these claims.

Planning proponents frequently point to studies by Ford, DaimlerChrysler and General Motors that compare health care costs in states where they have employees. For example, DaimlerChrysler says its costs ranged from $1,331 in New York, birthplace of Certificate of Need, to $3,519 per person in Wisconsin, which has a very limited Certificate of Need law. *[50]* The studies report that states with Certificate of Need laws had costs 11% to 39% lower than states without such regulations. These studies conclude that, cumulatively, all three automakers' health care costs were 30% lower in states with Certificate of Need laws. *[51]*

The research methods of the automakers' studies are fraught with difficulties. First, the studies only look at eight states, some with Certificate of Need laws and some without, and those states with such laws enforce them in varying degrees. *[52]* Moreover, these states are all in the same general region, making meaningful statistical conclusions difficult.

Second, the studies fail to establish a link between Certificate of Need laws and the cost of health care benefits. Built into the report is the assumption that because the cost of health care for a certain segment of the population (auto company employees) in a few states is less than in a few other states, Certificate of Need laws that are merely intended to reduce health care costs actually do work. One condition is not necessarily related to the other, and unless a cause-and-effect relationship

can be established, the statistics are meaningless in the discussion of Certificate of Need's effectiveness.

Certificate of Need advocates use other, even less reliable, research conclusions. One oft-cited study claims that open-heart surgery mortality rates are 20% lower in states with Certificate of Need regulations than in other states. *[53]* A 1988 study, however, concluded the opposite of the above study; that Certificate of Need laws actually work to increase in-hospital mortality. *[54]*

Not long after the Federal Trade Commission and Department of Justice released their report critiquing Certificate of Need programs, the American Health Planning Association (AHPA) published a response. In it they attempt to highlight the benefits of Certificate of Need laws. Following is a point-by-point look at the AHPA's response. *[55]*

Claim: CON is a useful market balancing tool.

> Proponents of central planning say that in an imperfect and increasingly inequitable health care system, CON regulation is a flexible tool that, when used intelligently, helps protect the critical health care infrastructure that is essential to meeting both expected and unanticipated needs.
>
> If history has demonstrated anything, it is that the state has a poor track record when it comes to economic planning and forecasting. Yet that is exactly what the state attempts to do when it decides on the "need" for a local health care facility. Moreover, Washington's Certificate of Need program is not really "community-based," because it disregards community input that does not fit with pre-set planning formulas. The AHPA's rationale is flawed because it proposes to solve problems created by government intervention with more government intervention.

Claim: empirical evidence shows substantial economic and service quality benefit from CON regulation and related planning.

> The only source cited in this claim is a Journal of the American Medical Association article arguing that open-heart surgery mortality rates are 20% lower in states with Certificate of Need regulation. This is an isolated example that attempts to link the effects of regulation with a positive statistic. The empirical connection in this single instance is weak at best.
>
> Furthermore, numerous studies show that Certificate of Need regulation has had zero or negative impact on the quality of health service. One specialist in Walla Walla estimates that up to three people in the area die each year because a cardiac surgery center is not close enough. *[56]* State regulators denied a Certificate of Need to a local hospital that sought to open such a center.

Claim: CON regulation is one of the few practical planning tools available to policymakers.

> The underlying premise here is that public policymakers need to be involved in health care facility planning. But do they? Bureaucrats and central economic planning inhibit private provider's ability to supply necessary services to the public at reasonable prices. Government management and the third-payer system have distorted the market, and the cost problems we see today are the results. The solution is to encourage greater consumer

control and transparent pricing informed by unimpaired market inputs.

Central planners also use a volume and quality argument to justify Certificate of Need for tertiary services such as cardiac surgery, organ transplant, etc. The argument here is that by using Certificate of Need laws to concentrate volume at specialty hospitals, the quality of services provided there will increase.

This sounds attractive in theory, but in practice the evidence supporting the argument is weak While Washington's JLARC study concluded "the research evidence is strong that higher volumes of certain surgical procedures leads to better outcomes," it admits that this is true only for some procedures and that not all evidence supports the conclusion. *[57]* The same report found that Certificate of Need might reduce the quality of kidney dialysis services by reducing access *[58]* This point is of more than passing importance to kidney disease sufferers, to whom reduced access to reliable dialysis can prove fatal.

CON limits are of more than passing importance to kidney disease sufferers, to whom reduced access to reliable dialysis can prove fatal.

Some health care professionals have criticized the state's rationale for concentrating volume. Dr. Robert Johnson, a cardiologist in Walla Walla, once remarked that "our knowledge about how many operations have to be done by one surgeon to have good outcomes has changed since [the state placed CON regulations for volume]. It's not nearly as many as was thought to be the case." *[59]*

Attempting to control the geographic distribution of health care services is another way central planning reduces patient access. The government has offered special certification for regional centers of excellence in a given field so long as those institutions perform a certain number of procedures in a year. This produces two problems. First, the requirement concentrates certain health services in one geographic area, thereby creating a hardship for people who live out of the area. The added distance increases both patient cost and risk. Second, a facility that has to perform a certain number of procedures in a year to maintain government-sanctioned preferential status may be inclined to perform unnecessary procedures simply to boost its numbers.

VIII. Policy Recommendations

Washington Policy Center's recommendations for addressing the Certificate of Need issue are presented below in priority order, beginning with the most effective and far-reaching proposal for reform. Next, two alternatives are given that would ease the regulatory burden the program places on the state's health care system.

1. Repeal the Certificate of Need Law.

Washington should follow the example of the 14 other states that have repealed their Certificate of Need laws. Disaster did not follow repeal in those states, and it will not follow repeal in Washington. The 1999 JLARC study lists repeal a key policy option. Evidence cited by Certificate of Need proponents as justifying these complex regulations is inconclusive at best, and abundant evidence to the contrary shows that Washington's Certificate of Need law likely does more harm than good. The Certificate of Need law distorts important market signals that indicate when and where new health services will be needed. More than 30 years of experience shows that the Certificate of Need law acts as an impediment to achieving cost-effective, community-responsive health care.

2. Significantly Scale Back the Certificate of Need Law.

Short of outright repeal, many states have scaled back their Certificate of Need laws so they cover only a few types of facilities or only kick in at a higher expenditure threshold. For example, CON requirements should be eliminated for nursing homes to help meet the needs of an aging population. Partial repeal could be adopted as the first step to completely phasing out Washington Certificate of Need law.

Alternatively, the legislature could enact partial repeal with the intention of leaving a limited number of health services permanently under the control of Certificate of Need regulation. In both cases, partially repeal would allow time for the legislature to review the results. Lawmakers may find the Certificate of Need law works best when it applies only to a few medical specialties, while leaving most providers free to open new clinics, hospitals and nursing homes as health needs change in the community.

3. Authorize the Certificate of Need Task Force to Investigate Thorough Reforms.

In early 2005 the legislature created a special task force to examine the Certificate of Need program. The task force began meeting later that year and is charged with making recommendations on ways to improve and update the program. Even those who support the Certificate of Need program tacitly admit it is not lowering health care costs: "We need to look at the Certificate of Need program as a health planning process in relation to escalating health care costs." *[60]*

Unfortunately, the task force was hamstrung from the outset. In conducting its study the task force is required to presume "that the services and facilities subject to certificate of need should continue to be subject to it." *[61]* Given this restriction, genuine reform is not possible. The legislature should expand the task force's authority so its members can conduct a thorough investigation of the Certificate of Need program. The task force could then assess the program's actual performance compared to stated goals, review the experiences of other states and propose practical reforms that will improve health care access for Washington residents.

IX. Conclusion - Certificate of Need Represents the Failure of Government Central Planning

Three decades of experience has supplied ample evidence that Washington's Certificate of Need program has not worked as its creators intended. The law has not controlled costs, improved quality or increased access to health care. In fact, the law has had the opposite effect, actively blocking citizens' access to health care choices and to modernized health care facilities.

CON laws actively block citizens' access to health care choices and to modernized health care facilities.

There is, however, abundant evidence the process has become arcane and politicized, and that medical organizations holding Certificates of Need use the process to keep competitors out of their area. An indication of this effect is the program's use of non-medical criteria, like an applicant's record in providing charity care or the existence of any civil rights complaints, in deciding whether to approve a Certificate of Need.

In practice, Washington's Certificate of Need law is not about improving health outcomes for citizens, it is about controlling access to health care. The state's Certificate of Need process is more important in determining how and where patients will be treated than the decisions made by doctors and hospital administrators. This point is illustrated by an observation of economist

F.A. Hayek, "The power that a millionaire, who may be my neighbor and perhaps my employer, has over me is much less than that the smallest functionary possesses who wields the coercive power of the state, and on whose discretion it depends whether and how I am able to live or work." *[62]*

When health care organizations are allowed to compete with each other in a system that functions more like a normal market, consumers of health care win because there are both short- and long-term incentives for providers to innovate and grow more efficient. Robust competition builds a more nimble, community-responsive and consumer-centered system that readily adapts to changing needs. Inflexible planning and regulatory structures that keep competitors out cannot achieve this

The program's record indicates the Certificate of Need law no longer serves the public interest, if indeed it ever did. The stated purpose of the program is to foster a health care system that controls costs and meets changing conditions. Yet, to succeed such a system requires the very flexibility the Certificate of Need is designed to prevent. In a state experiencing rapid growth and demographic change, the Certificate of Need law prevents providers from adapting to the changing health needs of the community.

Three Case Studies

1. A Flawed Process

When the Department of Health decided in June 2005 that Issaquah did not need a new hospital, it did so based on the proximity of three other hospitals. "If you put a point in the center of Issaquah, there are three hospitals within 12 miles," said Laurie Jinkins, assistant secretary of health-systems quality assurance for the state Department of Health. *[63]* She was referring to Overlake Hospital in Bellevue, Group Health Cooperative in Redmond, and Snoqualmie Valley Hospital. A closer look, however, reveals flaws in the state's decision.

First, Group Health Cooperative is not open to the general public. Only members of the Group Health insurance network can use Group Health services. Yet the state makes little adjustment for that fact in its calculation of hospital bed availability and need.

Second, Snoqualmie Valley Hospital has what one article called "a troubled past." It is a hospital that has been plagued "by maintenance mishaps, two closures and eroded credibility." *[64]* But it is a hospital with twenty-eight beds, and in spite of its demonstrated unreliability, its poor reputation and many people's refusal to go there, the state included those beds when calculating bed availability and medical need

This issue raises serious questions about the Certificate of Need determination process. Proponents of Certificate of Need planning tout the program as being "community based" or "community oriented," but in this case the process ignored two important community factors that influence the availability of hospital services to the public. An inflexible bureaucratic structure was unable to take account of legitimate local concern.

2. Stifling Competition Does Not Lower Costs

In May 2005, the Puget Sound Business Journal reported that a "statewide turf war" had erupted amongst providers of kidney dialysis, one of the many services covered by Washington's Certificate of Need law. Providers had filed more than a half dozen appeals regarding various dialysis station proposals. "I've never seen the number of appeals as high as now," one industry consultant observed. *[65]*

Several dialysis providers sought state permission to open new facilities or expand existing capacity. Rival companies fought Certificate of Need approvals as a way of preventing another provider from encroaching into their region. The business journal reported, "Appeals are becoming more common, as competition in the industry has surged with new market entrants." *[66]*

So what is the effect of hindered competition? Higher prices. "Private carriers used to pay $200 and $300 per treatment," remarked Palmer Pollock, a planning administrator with Northwest Kidney Centers, "now it's more than $1,000." Instead of reducing cost, as Certificate of Need laws are intended to do, kidney dialysis prices have increased by 330% - 500%. *[67]* This case shows how the Certificate of Need law not only fails to constrain rising health care costs, it actually puts upward pressure on the price of certain health services.

3. Ignoring Community Input

In the 1980s, the residents of Putnam County, Georgia, ran headlong into state Certificate of Need regulators. As their federal Representative reported to Congress:

"[T]he citizens of Putnam County are proud of their 20-year-old community hospital. They built it with local funding, without using any Federal Hill-Burton funds, and they still support it locally. They are proud enough to have recently approved a 1-cent sales tax to renovate the facility. They are not seeking an expansion. The hospital has always had 50 beds, and that's what they propose to maintain

"However, when Putnam County authorities went to the State health planning agency for the required approval under the certificate-of-need program this year, they ran into unexpected trouble. The agency looked over the request for the locally funded hospital improvements and decided to deny it - unless the hospital eliminated ten beds."

The state refused to budge and local health officials were forced to comply. Growth projections indicated that eventually all 50 beds would be needed, but the state insisted that ten of the beds be dismantled. They did so in spite of the fact that eliminating ten beds would reduce the number of nursing students the hospital could enroll, at a time when the country faced a shortage of nurses. Regulators also ignored the tremendous cost the community would incur later when hospital authority had to add back those ten beds.

This case shows how the centralized Certificate of Need process favors state-level regulators who insist on enforcing their decisions, regardless of the well-reasoned protests of local leaders.

Appendix

Description of the Certificate of Need Process for Hospital Beds

Following, in shortened form, is a description of the steps an applicant must take in requesting a Certificate of Need to build a new hospital or to add beds to an existing facility. Together, these steps represent one phase of a much larger process.

A. Develop Trend Information on Hospital Use

Steps 1 through 3: The hospital bed need determination begins with compiling historical use data-that is, how many days patients spent in ho· als based on types of treatment. (The state makes a distinction between time spent in a hospital for physical ... d psychiatric treatments. The need determination for psychiatric hospital beds is a separate process within the State Health Plan.)

Step 4: The state uses a ten-y ar history of hospital use rates to determine historical trends.

B. Calculate Bed Need Forecasts

Steps 5 and 6: Each of Washington's hospital planning area's (how the state divides the population of large areas into geographic units for planning purposes) hospital use rates are computed. At a minimum, two age blocks need to be considered: people age zero to 64 and people over 65. Age groups may be divided further.

Step 7A: The state for casts each hospital planning area's use rates. It does this based on historical trends and projections made by the Office of Financial Management. The forecast is done for a target year, which varies. It can be as little as five or six years. *[69]* Moreover, the trends are arranged according to age group. Once determined, these trends are adjusted up or down, in proportion to the trend of either the statewide ten-year trend or the specific planning area's ten-year trend.

Step 7B: This is an alternative to Step 7A. In planning areas where a Health Maintenance Organization is present, adjustments must be made to factor in HMO enrollees. These adjustments are necessary because HMOs can control where their enrollees go for hospital care.

Steps 7B.1 through 7B.3. These steps serve to illustrate and correct skews created by HMO enrollment in a hospital planning area.

Steps 8 through 10: Here the bed need forecasts begin to take shape. Trend-adjusted use rates (see Steps 7A and 7B) and projected population are used to determine total forecasted patient days. Forecasted patient days are then distributed to hospital planning areas based on market share and the use of out-of-state hospitals. Average occupancy standards are then used to determine each planning area's bed need.

C. Determine Total Hospital Bed Need Forecasts

Steps 11 and 12. The non-psychiatric bed need forecasts calculated from this process are added to the psychiatric bed need forecasts (calculated in a separate process) to determine overall bed need for all hospital services. Any necessary adjustments are then made-for example, population adjustments, use rates, market

shares, and shifts in occupancy rates.

It is important to note that these processes outlined here are only part of a much larger process for building a health care facility. These regulations are above and beyond standard county and city building permits, land use requirements, Growth Management limits, environmental impact statements, zoning regulations, building codes, construction review applications and public health standards. Naturally, these additional regulations are strictest for hospitals. Other regulatory factors applied to hospitals, in addition to Certificate of Need, include the following. *[70]*

Additional Requirements

Licensure and Physical Plant Requirements

- " Finishes (carpet, tile, wall covering)
- " Heating and ventilation system
- " Hot water system
- " Medication handling
- " Nurse call system
- " Room size, furniture & equipment
- " Shower and toilet fixtures

Fire / Life Safety Requirements

- " Automated sprinkler system
- " Electrical generator system
- " Fire alarm system
- " Fire / life safety structural design
- " Life support system
- " Medical gas system
- " Smoke control system

Standards Adopted by State Building Code Council

- " 2003 International Building Code
- " 2003 International Fire Code
- " 2003 International Mechanical Code
- " 2003 International Plumbing Code
- " Barrier-free requirements
- " National electrical code
- " Washington state energy code
- " Washington state ventilation code

These regulations are important to protecting public health and safety, and there is no suggestion that this requirement should be loosened or repealed. The purpose here is to show that the lengthy and complicated Certificate of Need process is imposed in addition to a long list of existing requirements.

About the Author

John Barnes is a policy analyst for Washington Policy Center and director of WPC's legislative information website, WashingtonVotes.org. He is the author of other WPC studies on education, transportation, health care, and government reform. Before joining WPC, John held the Robert M. Utley Editorial Fellowship with the Western Historical Quarterly in Logan, Utah. John is a graduate of Hillsdale College in Michigan and holds a Master's degree from Utah State University.

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PO Box 3643, Seattle, WA 98124-3643
ph 888 WPC-9272 • fx 888 943 9797

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REPRESENTATIVE BOB LYNN
District 31 Anchorage

E-Mail: Representative_Bob_Lynn@legis.state.ak.us
"Bob Lynn's Alaska Blog" AlaskaDistrict31.blogspot.com

Session:
Alaska State Capitol
Juneau, AK 99801-1182

Phone (907) 465-4931
Fax (907) 465-4316
Toll Free (800) 870-4391

Interim:
716 W 4th Ave, #650
Anchorage, AK 99501-2133

Phone (907) 269-0205
Fax (907) 269-0207

February 13, 2005

Ms. Karleen Jackson, Commissioner
State of Alaska
Department of Health and Social Services
P.O. Box 110601
Juneau, Alaska 99811-0601

Dear Commissioner Jackson,

This letter is to request a meeting with you and your Director of Administrative Services, Janet Clarke. My bill, HB 287 addresses Certificate of Need (CON) issues. Your Department recently submitted your cost scenarios of $41 Million Dollars to the Lieutenant Governor's office for inclusion on the signature gathering petitions on the same (CON) subject. These figures will likely be similar to HB 287. The primary difference between HB 287 and the Initiative is that HB 287 retains the CON for communities of less than 25,000 in population. The Initiative, on the other hand, would eliminate the CON throughout Alaska regardless of the population.

Obviously, a $41 Million fiscal note will severely impact my bill and this has me very concerned. The co-sponsors of my bill, Representatives Coghill, Chenault and Kohring share the same concerns. We need to understand how your office arrived at $41 million, how it was derived, and that the fiscal note be as accurate as possible.

We would appreciate a written response to the following questions.

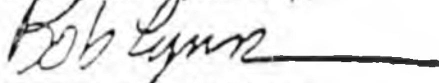
1. It is our understanding that independent facilities receive a flat rate for medical procedures under Medicaid and that hospitals receive additional facility and operational fees for the same procedures. Please identify for us the difference that you would pay to an independent facility and a hospital under Medicaid including all the additional fees paid to a hospital.
2. Of the facilities you have estimated would be built if CON were eliminated, how many of them would be considered to be independent facilities and how many would be considered hospitals eligible for the additional payments?

3. If these facilities are not eligible for the additional construction or operational payments, it would seem that there would actually be a reduction in costs to Medicaid since the number of Medicaid patients would remain the same regardless of the number of facilities. Please explain this.
4. What criteria were used to estimate the additional facilities? Were they considered to be necessary services not currently provided by other providers or were they facilities that have actually been proposed for development?
5. What criteria were used to estimate the number of beds in these facilities? They seem excessively large compared to other such facilities in much larger markets in the United States. For instance, the orthopedic hospital referenced in the note at 30 beds would compare to the orthopedic hospital in Houston, Texas at 48 beds, which serves a client base of 5 million people. The cardiac hospital also seems to be very large and as regards the 90-bed psychiatric hospital in Fairbanks, we are unaware of the level of psychiatric problems in the Fairbanks area that would justify 90 hospital beds.

After receiving your written answers to these questions, we would appreciate a meeting with you to discuss this issue. Nancy Manly, my Chief-of-Staff, will be able to coordinate our schedules to facilitate a meeting. I understand that OMB is also involved in this fiscal note issue. It may be useful to have an OMB representative there that could provide some independent evaluation, as well as someone from the Lt. Governor's office who will have to eventually issue the petition booklets.

Please let us know your intentions on these matters.

Thank you for your help,



Representative Bob Lynn

cc: Lt.Governor Loren Leman
Cheryl Frasca, OMB
Representative Coghill
Representative Chenault
Representative Kohring

STATE OF ALASKA

FRANK H. MURKOWSKI, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

PO BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE (907) 465-3030
FAX (907) 465-3068

March 1, 2006

Honorable Bob Lynn
Alaska House of Representatives
State Capitol, Room 415
Juneau, AK 99801-1182

Dear Representative Lynn,

I apologize for the delay in responding to your questions related to the certificate of need (CON) program included in your letter to me of February 13, 2006. The questions and responses follow:

Question 1: *It is our understanding that independent facilities receive a flat rate for medical procedures under Medicaid and that hospitals receive additional facility and operation fees for the same procedures. Please identify for us the differences that you would pay to an independent facility and a hospital under Medicaid including all the additional fees paid to a hospital.*

Response: Medicaid pays for Ambulatory Surgical Center services through an all inclusive rate for the service provided. The payment rates are based on an Alaska adjusted, national Medicare rate. The rate is annually adjusted for inflation.

Medicaid outpatient hospital payment rates are established using a significantly different methodology. Outpatient rates are based on a percentage of allowable charges derived from cost reports provided to the State by the facility.

When a certificate of need is approved and the hospital opens a newly approved inpatient project, the payment rate is adjusted, to include the allowable capital costs of the new project. We assume this increase is the additional fees amount referred to in your question.

Outpatient hospital rates are also adjusted for new CON approved costs when certificate of need project costs and charges become part of an outpatient hospital's cost basis for rate setting.

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Question 2: *Of the facilities you have estimated would be built if CON were eliminated, how many of them would be considered to be independent facilities and how many would be considered hospitals eligible for the additional payments?*

Response: We assume you are asking which projects would fall under the facility rate setting methodology as opposed to those who would be paid an all inclusive rate for the services provided as described in our response to question #1 (above). Health care facilities subject to the facility rate setting methodology are hospitals (general acute care, acute psychiatric, and long-term acute), skilled nursing facilities/intermediate care facilities (nursing facilities), and rural health clinics. Some of the projects included in the department's cost estimates for the proposed initiative may be independent facilities OR may be subject to formal facility rate setting—depending where the project is located. For example, an outpatient surgery suite built as an addition to an existing acute care hospital would be subject to a different payment methodology than an ambulatory surgery center built and licensed as a stand-alone facility.

Question 3: *If these facilities are not eligible for the additional construction or operational payments, it would seem that there would actually be a reduction in costs to Medicaid since the number of Medicaid patients would remain the same regardless of the number of facilities. Please explain this.*

Response: Independent facility payment rates include necessary capital and operations costs while hospital payment rates are facility specific and do not include necessary capital costs until the certificate of need adjustment takes place. Capital rate adjustments alone would not appear to generate a cost to the system beyond what would be reasonable. Over the long term the hospital rate adjustments makes the in-patient and out patient hospital rates comparable and does not necessarily drive Medicaid costs up or down.

Question 4: *What criteria were used to estimate the additional facilities? Were they considered to be necessary services not currently provided by other providers or were they facilities that have been proposed for development?*

Response: The estimates prepared were based on materials and information received by department staff including prior letters of intent, inquiries, prior certificate of need applications, and knowledge of recent trends in other states. The projects are representative of health care facilities that would likely be pursued by private developers in the future; but should not be regarded as a definitive list. The department is not suggesting that a need could be demonstrated for any particular project (this could only be determined if a certificate of need application was submitted and the appropriate analysis conducted). Rather, based on the best information available, the department is suggesting that these projects are representative of what would likely be pursued should the proposed initiative become law.

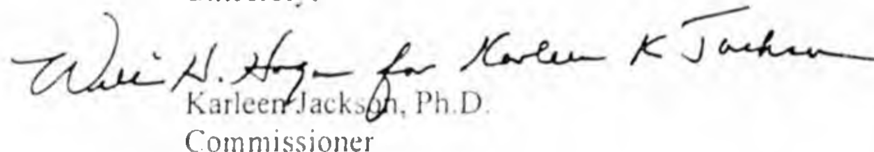
Question 5: *What criteria were used to estimate the number of beds in these facilities? They seem excessively large compared to other such facilities in much larger markets in*

the United States For instance, the orthopedic hospital referenced in the note at 30 beds would compare to the orthopedic hospital in Houston, Texas at 48 beds, which serves a client base of 5 million people The cardiac hospital also seems to be very large and as regards the 90-bed psychiatric hospital in Fairbanks, we are unaware of the level of psychiatric problems in the Fairbanks area that would justify 90 hospital beds

Response: See response to # 4 above

Finally, please recognize that House Bill 287 as introduced is significantly different than the proposed certificate of need initiative. House Bill 287 eliminates certificate of need requirements for nursing facilities and residential psychiatric treatment centers in much of the state. This would likely result in significant additional costs to the department insofar as both of these facility types are supported largely by Medicaid. A fiscal note for House Bill 287 will be forthcoming shortly.

Sincerely,



Karleen Jackson, Ph.D.
Commissioner

STATE OF ALASKA

FRANK H. MURKOWSKI, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

PO BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE (907) 465-3030
FAX (907) 465-3068

March 13, 2006

The Honorable Bob Lynn
Representative District 31
State Capitol, Room 415
Juneau, Alaska 99811

The Honorable Mike Chenault
Representative District 34
State Capitol, Room 505
Juneau, Alaska 99811

Dear Representative's Lynn and Chenault:

The following information is provided in response to our meeting of March 1, 2006 and your subsequent letter of March 2, 2006 related to HB 287 and the Certificate of Need (CON) program.

- ***Per request of both Representatives, please provide a revised fiscal analysis with a CS for HB 287; explain in detail how the fiscal analysis is derived.***

Outlined below is a summary of the impact to the Medicaid program of HB 287 based on the revised committee substitute. Please note, one of the costliest items in the fiscal note is the inpatient psychiatric beds, where Medicaid is a primary payor. Details of the fiscal analysis is provided on ATTACHMENT #1, where we have provided Draft fiscal notes.

CS HB 287
Limiting CON for facilities (other than NH & RPTC) to areas with population of 25,000+

Summary of Fiscal Notes

All Medicaid Components

	State Fiscal Year					
	2007	2008	2009	2010	2011	2012
Total	$2,373 5	$4,747 0	$7,142 4	$14,546 6	$16,195 1	$45,667 2
Federal	$1,366 6	$2,733 3	$3,602 6	$7,273 3	$8,097 6	$22,833 6
GF Match	$1,006 8	$2,013 7	$3,539 8	$7,273 3	$8,097 6	$22,833 6

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- ***Please provide a history of CON applications for the last ten years to see what historical has occurred with the CON program as a basis for what could happen in the future.***

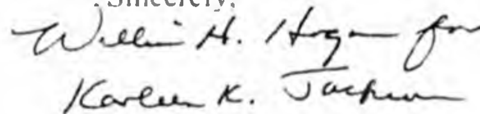
Please see ATTACHMENT #2

- ***Please provide a theoretical example of what Medicaid would pay based on cost associated with Outpatient Hospital treatment vs. Ambulatory Surgical Center.***

Please see ATTACHMENT #3 with two different examples; the first is "Treatment for Fractured Arm" and the second is for "Cat Scan of Abdomen".

If you have questions concerning this information, please feel free to contact either Tony Lombardo at 465-3030 or Janet Clarke at 465-1630.

Sincerely,



Karleen K. Jackson, Ph.D
Commissioner

Attachments 1-3

Cc: Deputy Commissioner Lombardo
Assistant Commissioner Clarke
Sherry Hill, Special Assistant
Elmer Lindstrom, Special Assistant
Dave Pierce, CON Program

Return

DRAFT

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS HB287 (HES)
( ) Publish Date:

Dept. Affected: Health & Social Services
Revision Date/Time (Note if correction)
Title: LIMIT CERTIFICATE OF NEED TO BOROUGHS WITH A POPULATION OF LESS THAN 25,000
RDU: Behavioral Health
Component: Behavioral Hlth Medicaid Svcs

Sponsor: LYNN
Requester: HOUSE (HES)
Component No: 2660

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						26,724.4
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	26,724.4
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						13,362.2
1003 GF Match						13,362.2
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	26,724.4

Estimate of any current year (FY2006) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal: [ ]

POSITIONS

Full-time						
Part-time						
Temporary						

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

CS HB287 amends the certificate of need (CON) by exempting certain health facilities in the most populated areas from the program. The current CON program applies to all areas of the state (AS 18.07). This bill would apply CON only to health facilities (other than nursing homes and residential psychiatric treatment centers) in the less populated areas of the state: (a) boroughs with a population of less than 25,000, (b) the unorganized borough, and (c) communities with a critical access hospital.

Continued

Prepared by: Janet Clarke, Assistant Commissioner
Phone:
Division: Finance & Mgmt Services
Date/Time: 03/08/2006
Approved by:
Date: 03/13/2006

STATE OF ALASKA
2006 LEGISLATIVE SESSION

BILL NO.CS HB287 (HES)

ANALYSIS CONTINUATION

Alaska law requires that a person who plans to undertake certain activities related to a health care facility or to convert a facility to a nursing home must first demonstrate a need for the proposed service and obtain a certificate of need from the Department.

The CON program applies to these health care facilities: private, municipal, state or federal hospital, psychiatric hospital, skilled nursing facility, residential psychiatric treatment center, independent diagnostic testing facility, tuberculosis hospital, kidney disease treatment center, intermediate care facility, and ambulatory surgical facility. Excluded are the Alaska Pioneer's Home and Alaska Veteran's Home and the offices of private physicians or dentists.

This bill would exempt facilities other than nursing homes and RPTCs in locations with population at or above 25,000 from the certificate of need requirement. It would eliminate the review of approximately 90%-95% of all certificates of need for the remaining health care facilities as almost all facilities are located in the exempt areas. Of the facilities currently subject to CON, 12 of the 25 hospitals co-located nursing facilities, and all of the 9 ambulatory surgical centers, 3 independent diagnostic testing facilities, 4 kidney dialysis centers, would be exempt under CS HB287. All of the 4 freestanding nursing facilities and 4 residential psychiatric treatment centers would still be subject to CON.

CS HB 287 would affect the 5 boroughs with population greater than 25,000: Municipality of Anchorage, Matanuska-Susitna Borough, Fairbanks North Star Borough, City and Borough of Juneau, and Kenai Peninsula Borough. Health care facilities and nursing home beds in these boroughs would not be subject to the CON process. Within the Kenai Borough, the community of Seward has a critical access hospital meaning that Seward is still covered by the CON program, but all other areas in the borough are not. Since the remainder of the state is either in a borough with a population less than 25,000 or is part of the unorganized borough the CON program would still be required in all other locations.

Based on interest expressed by health care providers and national trends the Department estimates that there are many projects in the exempt areas that would potentially start development immediately after the bill was passed. It is anticipated that construction on these facilities would peak within 3 years and that most, but not all, of the construction would be completed within 5 years.

In the Behavioral Health Medicaid component, the projects described below might be built if certain health facilties in the 5 largest boroughs are exempt from the CON program

ANALYSIS CONTINUATION

Note that Residential Psychiatric Treatment Centers are not exempt under CS HB 287.

The fiscal note is based on a list of potential projects. It is not possible to identify with any confidence which projects would or would not have been approved anyway, although we know that some would. The department's best estimate is that approximately 30% of the projects would have successfully completed the CON process. **The fiscal note represents the aggregate Medicaid costs for the 70% of potential projects affected by CS HB 287 that likely would not have received a CON.**

The uncertainty stems from several reasons: some projects are for new services that we do not have experience with yet; the standards for CON were recently changed and we do not have enough experience yet to speculate; some projects would not submit an application because the provider was aware that they were unlikely to receive the CON.

Alcohol and Drug Hospital: A couple of years ago a 30-bed facility in Anchorage was discussed with Department staff. The cost is based on similar types of facilities and would be about the same as an RPTC facility except without all of the educational and gym facilities. This specialty hospital would be licensed as a psychiatric hospital but serve alcohol and drug clients. *Estimated annual cost to Medicaid $16,607.5 starting in FY2012.*

Psych Hospital Beds: Valley Hospital has an empty 40-bed acute care facility that they are looking to sell or lease. They have contacted the Department on at least 3 occasions regarding the conversion of the facility to a psych hospital. If Fairbanks became a regional center and CON was not required, 40-60 beds would likely be built, primarily for adolescents and children. Last year North Star submitted a CON proposing development of 30 inpatient psychiatric hospital beds for children in Fairbanks. They would likely have planned for more if it were not for CON. In addition, Providence had plans up until recently to build a 60-bed psych facility in Anchorage. Although this facility will not be built, someone else might consider building a facility of that size. The costs per bed were estimated from recent CON applications. *Estimated annual cost to Medicaid $10,116.9 starting in FY2012 for a total of 90 beds.*

The GF match is based on the statutory SFY average FMAP for Title XIX for the appropriate year (2007-2008=57.58%; 2009=50.44%; 2010-2012=50.00%)

Return

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FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS HB287 (HES)
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: LIMIT CERTIFICATE OF NEED TO BOROUGHS WITH A POPULATION OF LESS THAN 25,000

RDU: Health Care Services
Component: Medicaid Services

Sponsor: LYNN
Requester: HOUSE (HES)
Component No. 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	2,373.5	4,747.0	7,142.4	14,546.6	16,195.1	18,942.7
Miscellaneous						
TOTAL OPERATING	**2,373.5**	**4,747.0**	**7,142.4**	**14,546.6**	**16,195.1**	**18,942.7**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
1002 Federal Receipts	1,366.7	2,733.3	3,602.6	7,273.3	8,097.6	9,471.4
1003 GF Match	1,006.8	2,013.7	3,539.8	7,273.3	8,097.5	9,471.3
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	2,373.5	4,747.0	7,142.4	14,546.6	16,195.1	18,942.7

Estimate of any current year (FY2006) cost:

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

CS HB287 amends the certificate of need (CON) by exempting certain health facilities in the most populated areas from the program. The current CON program applies to all areas of the state (AS 18.07). This bill would apply CON only to health facilities (other than nursing homes and residential psychiatric treatment centers) in the less populated areas of the state: (a) boroughs with a population of less than 25,000, (b) the unorganized borough, and (c) communities with a critical access hospital.

Continued

Prepared by: Janet Clarke, Assistant Commissioner
Phone:
Division: Finance & Management Services
Date/Time: 03/10/2006
Approved by:
Date: 03/13/2006
Agency: Department of Health and Social Services

FISCAL NOTE
FN #

STATE OF ALASKA
2006 LEGISLATIVE SESSION

BILL NO.CS HB287 (HES)

ANALYSIS CONTINUATION

Alaska law requires that a person who plans to undertake certain activities related to a health care facility or to convert a facility to a nursing home must first demonstrate a need for the proposed service and obtain a certificate of need from the Department.

The CON program applies to these health care facilities: private, municipal, state or federal hospital, psychiatric hospital, skilled nursing facility, residential psychiatric treatment center, independent diagnostic testing facility, tuberculosis hospital, kidney disease treatment center, intermediate care facility, and ambulatory surgical facility. Excluded are the Alaska Pioneer's Home and Alaska Veteran's Home and the offices of private physicians or dentists.

This bill would exempt facilities other than nursing homes and RPTCs in locations with population at or above 25,000 from the certificate of need requirement. It would eliminate the review of approximately 90%-95% of all certificates of need for the remaining health care facilities as almost all facilities are located in the exempt areas. Of the facilities currently subject to CON, 12 of the 25 hospitals/co-located nursing facilities, and all of the 9 ambulatory surgical centers, 3 independent diagnostic testing facilities, 4 kidney dialysis centers, would be exempt under HB287. All of the 4 freestanding nursing facilities and 4 residential psychiatric treatment centers would still be subject to CON.

CS HB 287 would affect the 5 boroughs with population greater than 25,000: Municipality of Anchorage, Matanuska-Susitna Borough, Fairbanks North Star Borough, City and Borough of Juneau, and Kenai Peninsula Borough. Health care facilities and nursing home beds in these boroughs would not be subject to the CON process. Within the Kenai Borough, the community of Seward has a critical access hospital meaning that Seward is still covered by the CON program, but all other areas in the borough are not. Since the remainder of the state is either in a borough with a population less than 25,000 or is part of the unorganized borough the CON program would still be required in all other locations.

Based on interest expressed by health care providers and national trends the Department estimates that there are many projects in the exempt areas that would potentially start development immediately after the bill was passed. It is anticipated that construction on these facilities would peak within 3 years and that most, but not all, of the construction would be completed within 5 years.

In the Health Care Services Medicaid component, the projects described below might be built if certain health facilities in the 5 largest boroughs are exempt from the CON program

http://www.internal.hss.state.ak.us/co/elmo/2003_fiscal_note_display_division.cfm?desig=HB&bi... 3/13/2006

FISCAL NOTE
FN #

STATE OF ALASKA
2006 LEGISLATIVE SESSION

BILL NO.CS HB287 (HES)

ANALYSIS CONTINUATION

The fiscal note is based on a list of potential projects. It is not possible to identify with any confidence which projects would or would not have been approved anyway, although we know that some would. The department's best estimate is that approximately 30% of the projects would have successfully completed the CON process. **The fiscal note represents the aggregate Medicaid costs for the 70% of potential projects affected by CS HB 287 that likely would not have received a CON.** The cost estimates are conservative because, while all will have additional costs for Medicaid, for some of the facility types we were unable to quantify the cost.

The uncertainty stems from several reasons: some projects are for new services that we do not have experience with yet; the standards for CON were recently changed and we do not have enough experience yet to speculate; some projects would not submit an application because the provider was aware that they were unlikely to receive the CON.

Ambulatory Surgery Centers: Based on letters of intent, prior CONs that were denied or withdrawn, or requests for information for surgery suites in a location. The cost is an average of recent surgery projects that submitted certificate of need applications. *Estimated annual cost to Medicaid: $2,196.7 with 12 beds added in FY2007 and another 14 beds in FY2008 and FY2009, for a total of 40 beds.*

Cardiac Hospital: Although the Department has not received any specific inquiries for this type of service it is growing around the country and interest in Alaska may not be too far off. The cost was estimated based on an average cost of acute hospital beds in recent CON applications. *Estimated annual cost to Medicaid: $2,747.6 with 30 beds starting in FY2010.*

Cardiac Cath Labs: Four Labs are expected in the next 3 years. Fairbanks Memorial Hospital is considering one or two Labs now. It is expected that competition for labs in Anchorage and the Mat-Su Valley would develop and that Soldotna will want the service also. *Estimated annual cost to Medicaid is unknown.*

Independent Diagnostic and Testing Facilities: Additional competition would be expected in this area with 7 new facilities starting up in Juneau, Soldotna, Fairbanks, Mat-Su and Anchorage. Information received indicates Alaska Open Imaging has considered opening in Juneau and Providence Imaging in Wasilla. These projects would likely all be built in 1-2 years. *Estimated annual cost to Medicaid is unknown.*

http://www.internal.hss.state.ak.us/co/elmo/2003_fiscal_note_display_division.cfm?desig=HB&bi... 3/13/2006

STATE OF ALASKA
2006 LEGISLATIVE SESSION

BILL NO.CS HB287 (HES)

ANALYSIS CONTINUATION

General Acute Care Hospital: Providence has indicated a need for 50-100 beds and Valley Hospital has a partially completed space for 75 beds. Soldotna and Fairbanks would be expected to add beds as well. The costs were estimated based on recent certificate of need applications. *Estimated annual cost to Medicaid: $8,242.8 for 200 beds, with 40 new beds added in each of the next 5 years.*

Kidney Dialysis Centers: One new 16-station facility may be developed in Anchorage. We did have one contact requesting information on certificate of need for such a facility. *Estimated annual cost to Medicaid is unknown. Probably not started until FY2010.*

Long Term Acute Care Hospital Beds: This is a new service that was approved for Anchorage in 2005. There may be an interest in developing these same services in Fairbanks and the Mat-Su Valley. Long Term Acute Care hospitals are specialty hospitals, without emergency rooms or outpatient services, designed to provide extended medical and rehabilitative care for critically ill, medically complex patients who have multiple acute or chronic conditions. Most patients in these facilities are age 65 and over. Their length of stay is too long for acute care, but their medical condition is not right for long-term care, plus they have an opportunity for rehabilitation. These services will be paid for primarily through Medicare and Medicaid. *Estimated annual cost to Medicaid: $3,008.0 for 90 total beds starting in FY2010.*

Radiotherapy: Three programs are expected. Inquiries have been made for this type of facility in Wasilla and Fairbanks and a letter of intent for expansion was received a couple of years ago for expansion of radiotherapy in Anchorage. *Estimated annual cost to Medicaid is unknown. Probably not started until FY2010.*

PET/CT Scanner: Fairbanks has indicated a continuing interest in this service even though a project was denied recently. A new one might be added in Anchorage. *Estimated annual cost to Medicaid is unknown. Probably started in FY2007.*

Orthopedic Hospital: Although none exists in Alaska, these specialty hospitals are growing rapidly in the rest of the US. It is only a matter of time before they move to Alaska. Costs were estimated to be similar to Cardiac Hospitals. *Estimated annual cost to Medicaid: $2,747.6 for 30 beds starting in FY2012.*

The GF match is based on the statutory SFY average FMAP for Title XIX for the appropriate year (2007-2008=57.58%; 2009=50.44%; 2010-2012=50.00%).

http://www.internal.hss.state.ak.us/co/elmo/2003_fiscal_note_display_division.cfm?desig=HB&bi... 3/13/2006

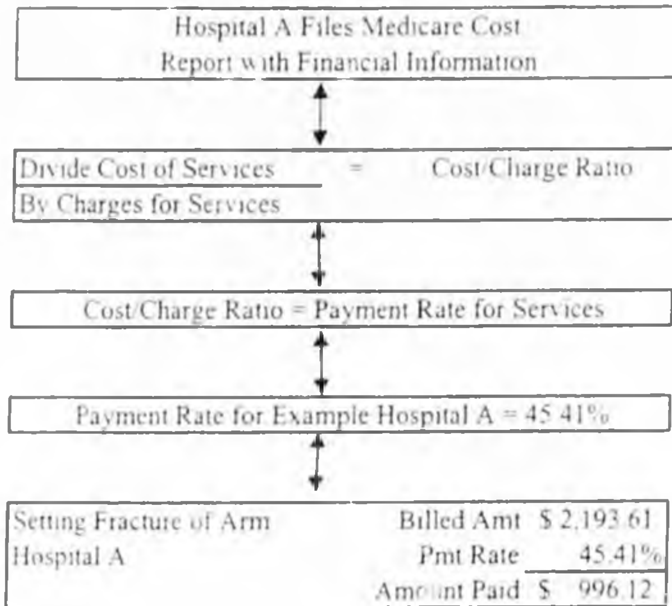
Certificate of Need Applications 1996-2005

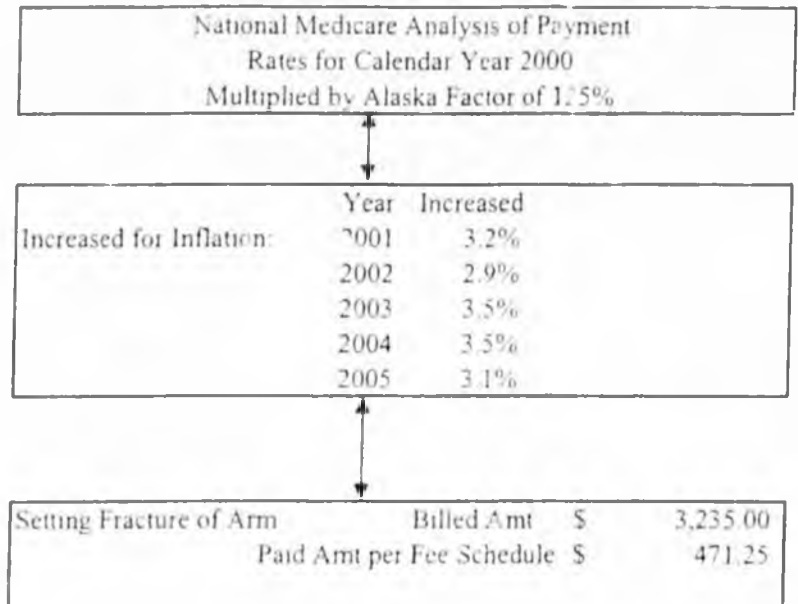
Year	Applicant	Location	Activity	Cost	Decision
2005	Fairbanks Memorial Hospital	Fairbanks	Emergency Dept Expansion	$ 33,202,843	Approved
2005	Boys & Girls Home & Family Svcs	Fairbanks	60 RPTC Beds	$ 14,750,000	Denied - did not meet Standards
2005	North Star Behavioral	Fairbanks	30 Psych & 30 RPTC Beds	$ 10,200,000	Denied - did not meet Standards
2005	PAMC/APCA Joint Venture	Anchorage	6-suite Ambulatory Surgey Ctr	$ 6,500,000	Denied - did not meet need Std.
2005	Doctors Surgery Center	Anchorage	2-suite Ambulatory Surgery Ctr	$ 8,000,000	Withdrawn
2005	ARH/AK Spine Institute	Anchorage	3-suite Ambulatory Surgery Ctr	$ 12,418,406	Withdrawn
2005	PAMC/PCC Joint Venture	Anchorage	60-bed Long-Term Hosp (LTACH)	$ 21,200,000	Approved
2005	North Star Behavioral	Anchorage	60-bed RPTC	$ 10,015,000	Approved
2005	Cornell Corporation	Anchorage	60-bed RPTC	$ 6,350,000	Withdrawn
2004	Providence (PAMC)	Anchorage	Open-Architecture MRI	$ 3,200,000	Approved
2004	Central Peninsula Hospital	Soldotna	Replacement Facility/Expansion	$ 49,611,816	Approved
2004	Fairbanks Memorial Hospital	Fairbanks	Outpatient Radiology Expansion	$ 36,069,090	Approved
2004	Ketchkan General Hospital	Ketchikan	Remodel of Long-Term Care	$ 4,012,631	Approved
2003	Providence AK Medical Ctr.	Anchorage	Linear Accelerator	$ 1,750,000	Approved
2003	Providence AK Medical Ctr.	Anchorage	CT Scanner	$ 1,120,000	Approved
2003	Valley Hospital - Palmer	Mat-Su Valley	76-bed Replacement Hospital	$ 87,800,000	Approved
2003	Providence AK Medical Ctr	Anchorage	Modification of the 2002 CON	$ 25,300,000	Approved/Withdrawn later
2003	Renal Care Group	Anchorage	Replacement Dialysis Center	$ 6,267,000	Approved
2003	Renal Care Group	Wasilla	Kidney Dialysis Center	$ 1,258,085	Approved
2003	Wildflower Court	Juneau	Add 5 LTC Beds	$ 863,550	Approved
2003	Providence AK Medical Ctr.	Anchorage	19-bed ICU Expansion	$ 11,300,000	Approved
2002	Providence AK Medical Ctr.	Anchorage	60-bed Psych Hospital	$ 21,000,000	Approved
2002	Wildflower Court	Juneau	Convert 11 Asst Liv Beds to LTC	$ 100,000	Denied
2002	Fairbanks Memorial Hospital	Fairbanks	Expand Clinical Laboratory	$ 12,900,000	Approved
2002	Alaska Psychiatric Institute	Anchorage	80-bed Replacement Hosp.	$ 41,744,000	Approved
2002	Renal Care Group	Fairbanks	Kidney Dialysis Center	$ 1,754,100	Approved
2002	Valdez Community Hospital	Valdez	21-bed Replacement Hosp.	$ 24,100,000	Approved
2002	Sitka Community Hospital	Sitka	Conversion of 5 beds to LTC	$ 30,000	Approved
2002	Providence AK Medical Ctr.	Anchorage	Mod. Of N. Tower/Lab Expand	$ 8,555,000	Approved
2001	Ketchkan General Hospital	Ketchikan	MRI Acquisition & Construction	$ 1,182,720	Approved
2001	Sitka Community Hospital	Sitka	Conversion of 5 beds to LTC	$ 13,500	Approved
2001	Providence AK Medical Ctr.	Anchorage	PET Scanner Purchase	$ 3,200,000	Approved/Withdrawn later
2000	Bartlett Regional Hospital	Juneau	Major Remodel & Expansion	$ 51,000,000	Approved
2000	Alaska Regional Hospital	Anchorage	Remodel & Additional surg space	$ 13,150,000	Approved
1999	Tanana Valley Clinic	Fairbanks	2-suite ASC	$ 4,206,722	Denied
1999	Fairbanks Ambulatory Surg. Ctr	Fairbanks	2-suite ASC	$ 5,509,500	Denied
1999	Fairbanks Memorial Hosp.	Fairbanks	1-suite ASC	$ 1,343,130	Denied
1999	South Peninsula Hospital	Homer	Remodel & add 10 NH Beds	$ 9,236,756	Approved 5 beds; $9.2M
1999	Providence AK Medical Ctr.	Anchorage	Remodel/Expand ER/N. Tower	$ 25,000,000	Approved as Requested
1999	Alaska Psychiatric Institute	Anchorage	54 Bed Replacement	$ 50,900,000	Withdrawn
1999	Fairbanks Memorial Hosp.	Fairbanks	11 bed MH expansion	$ 3,400,000	Approved as Requested
1999	Valley Hospital - Palmer	Mat-Su Valley	Major Renovation	$ 10,000,000	Approved as Requested
1999	Central Peninsula Hospital	Soldotna	MRI	$ 1,400,000	Approved as Requested

Attachment #2

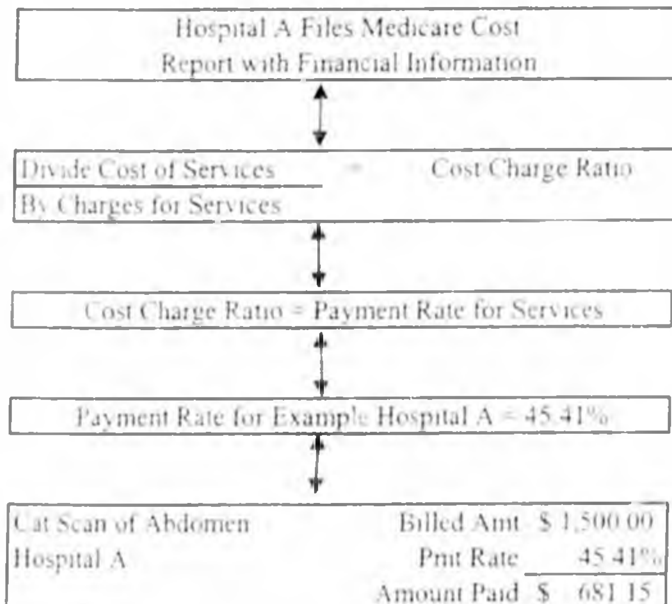
1998	A[illegible]ka Regional Hospital	Anchorage	Open Heart S[illegible]/Trauma	$	1,300,000	Approved/1-OH suite sh[illegible]d in to 03
1998	A[illegible]a Regional Hospital	Anchorage	Open Archi[illegible]ure MRI	$	1,300,000	Approved as Req[illegible]ed
1998	Fairbanks Surgery Center	Fairbanks	Extension of Time Period	$	2,900,000	Denied
1998	St. Ann's Care Center - Juneau	Juneau	44-Bed Nursing Home/replacement	$	18,500,000	Approved as Requested
1997	Providence AK Medical Ctr.	Anchorage	Remodel/Expand Heart Ctr.	$	1,520,000	Approved as Requested
1997	Bartlett Regional - Juneau	Juneau	Expand OR/Outpatient/New Adm	$	6,800,000	Approved as Requested
1997	Valley Hospital - Palmer	Mat-Su Valley	60-Bed Nursing Home	$	6,700,000	Withdrawn
1997	Providence AK Medical Ctr.	Anchorage	Childrens Hospital	$	7,000,000	Approved as Requested
1996	Providence AK Medical Ctr.	Anchorage	Cardiac Cath Lab Expansion	$	3,499,908	Approved as Requested
1996	Providence Seward Med Ctr	Seward	Replacement Facility	$	7,800,000	Approved as Requested

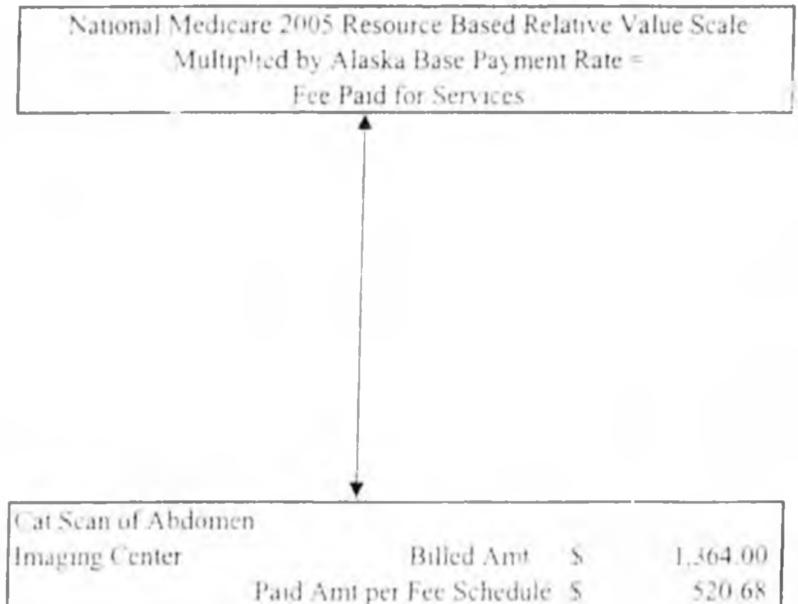
Treatment for Fractured Arm





Cat Scan of Abdomen





Attachment # 3

Alaska State Legislature

Chairman
Military & Veterans' Affairs Committee

Member
Labor and Commerce Committee
State Affairs Committee
Economic Development, Trade & Tourism Committee
Education Committee
Joint Armed Services Committee

Finance Subcommittees
Labor & Workforce Development
Community & Economic Development
Military & Veterans' Affairs

A Communication From
REPRESENTATIVE BOB LYNN
District 31 Anchorage

E-Mail: Representative_Bob_Lynn@legis.state.ak.us
"Bob Lynn's Alaska Blog" AlaskaDistrict31.blogspot.com

Session:
Alaska State Capitol
Juneau, AK 99801-1182

Phone (907) 465-4931
Fax (907) 465-4316
Toll Free (800) 870-4391

Interim:
716 W 4th Ave, #650
Anchorage, AK 99501-2133

Phone (907) 269-0205
Fax (907) 269-0207

March 23, 3006

Ms. Karleen Jackson, Commissioner
State of Alaska
Department of Health and Social Services
P.O. Box 110601
Juneau, Alaska 99811-0601

Dear Commissioner Jackson,

Thank you for your letter of March 13, 2006 concerning the fiscal note for HB 287. Much of the information is useful, but I am still having difficulty understanding the specific mechanism by which HB287 adds costs to Medicaid. Perhaps answers to specific questions will help me.

It's still not clear to me what part of HB 287 will cause Medicaid costs to increase.

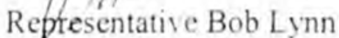
1. Would HB 287 cause an increase in the number of eligible Medicaid recipients? If so, how?
2. Would HB 287 cause additional services to be offered which are not currently available to Medicaid recipients in Alaska? It is my understanding that, if services are not available in Alaska, Medicaid recipients will be sent to outside facilities to receive treatment. If people don't have to be flown out for treatment, wouldn't the cost be lower?
3. Why would HB 287 cause services to be more expensive than what is charged by existing providers? According to the pricing worksheet you provided in your example of a fractured arm, both procedures were less expensive (more than 50% less) than the same procedure provided in a hospital setting. If these numbers are accurate, then would not HB 287 have a negative fiscal note indicating the savings to the State?

4. You claim that providing services in facilities that would qualify for the additional facility fees could cause Medicaid costs to go up, for example Medicaid subsidies such as the DISH payments to hospitals. But in your letter dated March 13, you indicated that the only facility you could imagine in this category would be a surgery center physically connected and adjunct to a hospital. So if none of the facilities would be paid more, how would this generate a higher fiscal note?

Please help me understand how any of these items mentioned above would apply to HB 287. Is there some other mechanism that increases Medicaid costs?

Thank you in advance for your help on the questions mentioned above. Currently, HB287 has been scheduled for a hearing in House HESS Committee on March 28. It would be appreciated if I can get a **written response** before that time.

Sincerely,



Representative Bob Lynn

cc: Representative Coghill
Representative Chenault
Representative Kohring

Outdated Law Is Driving Up Health Care Costs for Alaskan's

Alaska's rising health care costs are hurting our families, raising worker's compensation costs, putting health care insurance out of economic range for individuals and companies, and raising Medicaid and Medicare costs throughout the state. A driving force behind our increasingly high medical costs can be attributed to a little known and archaic state law called Certificate of Need (CON).

In 1974 Congress passed a law requiring all to states to implement Certificate of Need programs requesting permission from their respective states in order to build and maintain medical facilities. If states did not comply the federal government would withhold funding, creating strong incentives for states to implement far-reaching health care planning regulations. In the 1980's the philosophical shift to promoting competition in the health care industry in order to reduce prices fueled significant controversy regarding CON regulations. As a result, in 1986 Congress repealed the federal CON requirements, but nevertheless Alaska has kept the law intact.

Alaska's Certificate of Need law requires medical facilities to receive state approval before construction of new clinics or surgery centers; an anti-competitive activity that would be severely punished by federal anti-trust laws if attempted by private companies but is sanctioned and promoted by the state of Alaska. This law directly stifles price competition by blocking new competitors from entering the market. So significant are these restrictions to competition and reduction in costs that every state West of the Missouri (save for Washington) has since repealed or significantly minimized the CON requirements. Alaska currently maintains the second most restrictive CON regulations in the country, behind only Connecticut. It doesn't take an economist to understand that increased competition results in lower prices for the consumer, something this state desperately needs.

A House Bill (#287) was introduced last April which would repeal CON laws in Alaska except in communities of 25,000 or less. This Bill, if passed, would have tremendous economic effect on the residents of Alaska in the form of huge health care savings by effectively wrestling the monopolistic control hospitals exert on our residents health care costs. It would allow surgery centers to compete with hospitals for consumers the way every other industry must. The result of such competition would be lower prices, increased access, and more efficient care.

Unfortunately for all of us, House Bill 287 has yet to be heard in the House of Representatives and is therefore being denied the opportunity for approval. Representatives Bob Lynn, John Coghill Jr., Mike Chenault, and Vic Kohring should be commended for keeping the best interests of Alaskan's at heart by sponsoring this Bill. It is now these very residents however, who are burdened with the public support required to have this Bill heard in the House. Contact your Representatives and Senators today in support of House Bill 287; it's about time Alaskan's are given an answer to their quest for affordable medical care.

Paid for by Advanced Medical Centers of Alaska
1017 Abbott Road, Suite 10[illegible], Anchorage, AK 99507

Juneau Empire
3-19-06

Alaska Physicians & Surgeons, Inc.

4120 Laurel Street, Suite 206, Tel: (907) 561-7705 Fax: (907) 561-7704
E-mail: akphys@alaska.net Website: www.apsdoctors.org
Executive Director: Michael Haugen, Executive Assistant: Phyllis Finley

APS News
Nov/Dec 2005

www.apsdoctors.org

2005 APS Year-end Review

2005 will be remembered as APS' and the medical communities most successful legislative year in the past two decades. With passage of real, meaningful medical liability reform, Alaska has vaulted into the top tier of states that have taken the problem of our out of control medical tort system seriously. The new lower caps on non-economic damages should help stabilize the medical liability insurance market in Alaska. However, the law will be challenged by the trial bar, and to defend it APS has teamed up with several other entities and associations to form the Alaskans for Access to Healthcare (AAHC). AAHC is in the fight for the long haul because challenges to laws like this typically take between 3-6 years to reach the Supreme Court of Alaska. APS will be there every step of the way.

Two of APS' 2005 legislative priorities will carryover into 2006; 1.) amending the Alaska Healthcare Decision Act to cure several unintended consequences that affect the patient/physician relationship, and 2.) monitor the legislatures efforts as it attempts to address imbalances in Alaska's Workers Compensation system.

In early November the APS Board of Directors held its annual strategic planning meeting to set APS' 2006 legislative and other priorities.

In addition to the issues carried over from 2005, new initiatives will be:

1.) to seek passage of an Alaska "Any Willing Provider" statute, 2.) elimination of Alaska's ineffective and anti-competitive Certificate of Need Law, 3.) support and help find funding for expansion of the WAMI program to 20 slots, and 4.) continue to raise funds through APS' Political Action Committee (APSPAC) to support physician and patient friendly legislative candidates.

It should be noted that APSPAC has been hugely successful this year and is now the largest and best funded physician directed PAC in Alaska. In September APSPAC in conjunction with ASMA's PAC (ALPAC) held a political fundraiser in Girdwood and over $60,000 was raised, propelling Alaska's physicians into the top ranks of fundraisers in the state.

Welcome New APS Member (s):

John Lapkass - Orthopedic Surgeon

Amerinet 2005 Contract Utilization

APS' relationship with Amerinet, our group purchasing organization, continues to blossom. More member offices are taking advantage of the hundreds of discounted contracts that Amerinet has negotiated with local & national vendors for office supplies, pharmaceuticals, medical supplies and equipment, and much more. 2005 will be our best year ever with total activity and sales volume up by over 30% to well over 3 million dollars. For more information on buying opportunities contact the APS office at 561-7705.

Board of Directors:

President - John Duddy, MD
Vice Pres—Michael Norman, MD
Sec/Treasurer - John Mues, MD

Roland Gower, MD
Robert Hall, MD
Hedric Hanson, MD
Lynn Hornbein, MD
Leland Jones, MD
William Lucht, MD
Richard Neubauer, MD
George Rhyneer, MD
Paul Steer, MD
Thomas Vasileff, MD

Mark Your Calendars... APS Annual Dinner Meeting

Date: Tues, January 17, 2005

Time: 6:00 pm - 8:00 pm

Place: Hotel Captain Cook - Fore Deck

(Invitations will be sent in December)

Countrywide Mortgage Offer to APS Member Offices and Staff

If you are considering refinancing or buying a home you may want to contact Countrywide Mortgage soon. APS members have saved thousands of dollars by financing through Residential Mortgage in the past. Jeff Stanford formally of Residential has moved to Countrywide and has offered the following Countrywide Mortgage discounts to APS members and their staff.

- No loan origination fee
- No cost equity loans
- No underwriting fee/processing fee
- Guaranteed lowest jumbo rates in Alaska
- 1% interest rates available up to 1 million

For further information you can contact Jeff Stanford, Mortgage Loan Originator directly at 343-3636.

Fairbanks Daily News-Miner

Group wants health care law changed
By STEFAN MILKOWSKI
Staff Writer

Thursday, January 19, 2006 - A group of legislators and health-care providers is pushing to drastically reduce the reach of the state law governing development of new health care infrastructure.

Supporters would change the certificate of need law, which requires developers of medical facilities to prove that the facilities are needed, to cover only long-term nursing care facilities and residential psychiatric treatment centers.

Lt. Gov. Loren Leman approved petition language Tuesday for an initiative effort to change the certificate of need law. The initiative is similar to one proposed last year and to a bill introduced in the state House of Representatives in 2005.

Rep. Bob Lynn, R-Anchorage, sponsored the legislation as well as this year's ballot initiative.

"We're trying to protect free enterprise," he said. "If we can have more competition, it's likely we can have lower costs."

The issue promises to be contentious.

The certificate of need legislation was designed to prevent "excessive, unnecessary, or duplicative development of facilities or services," according to the Department of Health and Social Services' Web site.

The DHSS, which administers the certificate of need program, warns that limiting the legislation to nursing care and mental health facilities could actually cause an increase in statewide health care costs rather than the decrease promised by proponents of the new initiative.

The effective gutting of the law could eventually put some hospitals out of business, said Rep. Paul Seaton, R-Homer and vice-chairman of the House Committee on Health, Education and Social Services.

The initiative is sponsored by Reps. Lynn and Vic Kohring, R-Wasilla, and Paul Fuhs, a lobbyist.

A coalition of independent health-care facility owners, doctors and small business owners swamped by health insurance premiums supports the initiative, Fuhs said. Supporters formed the nonprofit organization Alaskans For Medical Choice and Competition to promote the change.

Alaska Open Imaging Center, which opened its fourth statewide facility Monday in Fairbanks, is a member of the group. The company skirted certificate of need regulations because the new facility qualifies as a physicians' group rather than an independent testing facility.

In 2005, Fuhs helped draft an initiative that would have eliminated certificate of need requirements for

urban Alaska and left them in place for rural Alaska. The initiative was not certified by Leman because it included "local and special legislation," which is prohibited from initiatives by the Alaska Constitution.

House Bill 287, introduced in April 2005 by Lynn, Kohring, Rep. John Coghill, R-North Pole, and Rep. Mike Chenault, R-Nikiski, would make the same changes and is not prohibited by the constitution.

On Tuesday, Leman certified the rewritten initiative, which Fuhs described as a "backstop." If HB 287 is passed, the initiative will likely be dropped, he said, as either would accomplish the group's goal.

In order for the initiative to reach the ballot, sponsors will need to collect 31,451 signatures from registered Alaska voters, reflecting 10 percent of votes cast in the 2004 general election.

Lynn said he supports the initiative both on principle and for its practicality.

Under the current law, someone seeking to create a health-care facility has to go "hat in hand" to the government and beg, he said.

"We should have the freedom to open any kind of business," he said.

Lynn said the bill was practical because the competition it allowed would lower health-care prices and increase quality.

He likened it to a customer having 100 cars to choose from or one.

"It's just that simple," he said.

Others argue it's not.

Rep. Sharon Cissna, D-Anchorage and a member of the health committee, said she also recognizes the strain placed on health-care consumers and providers by high costs of care. Most of the communities she has visited are facing troubles with health-care costs, she said.

"I don't think HB 287 is how you fix that," she said.

Cissna said limiting the certificate of need law would allow private companies to compete with hospitals on the most lucrative medical services and eventually threaten their livelihood.

Seaton, vice-chairman of the House health committee, said the most lucrative services, such as surgery and testing, help hospitals pay for "charity care," or care provided to patients with minimal or no insurance, as required by law.

Taking that business away from hospitals is "really problematic to maintaining an adequate health-care system for Alaskans," he said.

Representatives from Fairbanks Memorial Hospital did not return calls for comment.

The DHSS estimates that the law change could allow up to $373 million to be spent on new health-care

facilities across the state, including walk-in surgery centers, general- and acute-care hospitals and independent diagnostic and testing facilities in Fairbanks, according to information provided by Leman's office.

The new facilities could increase Medicaid costs to the state by $20.6 million annually, according to the DHSS calculation.

Advocates of changing the law point to a report published in 2004 by the U.S. Department of Justice and the Federal Trade Commission.

The report found that, "On balance, CON programs are not successful in containing health care costs. ... Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market."

Staff writer Stefan Milkowski can be reached at smilkowski@newsminer.com or 459-7577.

Certificate of Need Initiative Certified

For Immediate Release: January 17, 2006

Lieutenant Governor Loren Leman today certified an application for an initiative petition amending the certificate of need requirement to apply only to facilities providing long term nursing home beds and residential psychiatric treatment centers.

The initiative's prime sponsors are Paul Fuhs, Representative Vic Kohring and Representative Bob Lynn.

Sponsors will need to collect 31,451 signatures from registered Alaska voters to qualify the initiative for a vote of the people. This is 10 percent of the 314,502 votes cast in the 2004 general election. Under the constitutional amendment approved by voters in 2004, signatures are needed from at least seven percent of voters in at least 30 of the 40 Alaska House Districts. Sponsors will have one year from the time they receive petition booklets to collect the required signatures.

This is the first initiative subject to the requirements of HB 94 (FSSLA 2), which had an effective date of September 22, 2005. This bill requires the Division of Elections to estimate the cost to process and review each initiative, and each affected department to estimate the minimum costs to the State associated with the initiative.

The Department of Health and Social Services estimates that this change could allow health care construction capital expenditures of up to $373.4 million without review by the Department. This could increase Medicaid costs by up to $41.2 million annually, of which $20.6 million would be State General Funds, for operations and depreciation expense under the current Medicaid rate-setting statutory and regulatory process. The Division of Elections estimates it will cost $39,800 to review and process this initiative. **Click here** for the full explanation of estimated costs.

To view the Department of Law recommendation for this initiative **click here**. To view the certification letter for this initiative **click here**. To view the text of the proposed initiative **click here** for The Division of Elections web site.

Note: Initiative petitions are not "approved" or "disapproved" by the Lieutenant Governor, rather they are "certified" or "not certified." State law specifies criteria that must be met for an initiative to be certified.

Potential Alaska Projects if CON is Eliminated for all but Residential Psychiatric Treatment Centers and Nursing Home Beds						
Type of Facility	Locations	Est. No. of Units	Estimated Facility Life	Annual Cost to Medicaid*	Estimated Total Construction Cost	Estimated Construction Cost per Unit
Ambulatory Surgery Centers	Juneau, Homer, Soldotna, Fairbanks, Anchorage, Mat-Su	40 Suites	25 years	$ 2,857,143	$ 62,782,410	$ 1,569,560
Long-Term Acute Care Hosp	Mat-Su, Fairbanks	90 Beds	25 years	$ 4,297,174	$ 31,800,000	$ 353,333
Cardiac Hospital	Anchorage	30 Beds	25 years	$ 3,925,139	$ 10,600 000	$ 353,333
Cardiac Cath Lab	Anchorage, Mat-Su, Fairbanks, Soldotna	4 Labs	5 yrs equip, 25 yrs bldg	No Data	$ 10,000,000	$ 2,500,000
Psych Hospital	Fairbanks, Anchorage	90 Beds	25 years	$ 14,452,739	$ 26,587,530	$ 295,417
Independent Diagnostic & Testing Facilities	Juneau, Sodotna, Fairbanks, Mat-Su, Anchorage	7 Facilities	5 yrs equip; 25 yrs bldg.	No Data	$ 28,700,000	$ 4,100,000
General Acute Care Hospitals	Fairbanks, Mat-Su, Anchorage	200 Beds	25 years	$ 11,775,418	$ 179,473,700	$594,737-$1,120,000
Kidney Dialysis	Anchorage	16 Stations		No Data	$ 2,000,000	$ 2,000,000
Radiotherapy	Anchorage, Fairbanks	2 Programs	5 years Equip	No Data	$ 8,200,000	$ 4,100,000
PET/CT Scanner	Anchorage	1 New	5 years	No Data	$ 3,200,000	$ 3,200,000
Orthopedic Hosp	Anchorage	30 Beds	25 years	$ 3,925,139	$ 10,600,000	$ 353,333
				$ 41,232,752	$ 373,943,640	
	*Includes operating and construction costs					

Estimated Costs for Reviewing and Processing 05CHA2 Petition

PERSONAL SERVICES:								$33,631.29
	PCN	Name	R/S	Salary	Bens.	LOC	HIRING PERIOD	
FULL-TIME PERMANENT:								$4,707.77
Election Coord.	502X	Allred	17F	$3,033.00	$944.48	AWA	Full-time for 15 days	$3,977.48
Elec Prg Asst	525X	Noss	10B	$556.88	$173.41	AWA	Full-time for 5 days	$730.29
TEMPS:								$33,923.52
Petition Clerk		Temp	8A	$7,769.93	$710.95	AWA	Full-time for 81 days	$8,480.88
Petition Clerk		Temp	8A	$7,769.93	$710.95	AWA	Full-time for 81 days	$8,480.88
Petition Clerk		Temp	8A	$7,769.93	$710.95	AWA	Full-time for 81 days	$8,480.88
Petition Clerk		Temp	8A	$7,769.93	$710.95	AWA	Full-time for 81 days	$8,480.88
PRINTING:								$400.00
TRAVEL:								$806.00
Airfare	$500							
Per Diem	$75							
Lodging	$170							
Rental Car + Gas	$36							
Cab Fare	$25							
TOTAL								$39,837.29

MEMORANDUM

State of Alaska

Department of Law

To: The Honorable Loren Leman
Lieutenant Governor

Date: January 12, 2006

File No: 663-06-0076

Tel. No.: (907) 465-3600

From: Sarah J. Felix
Assistant Attorney General
Labor and State Affairs – Juneau

Subject: Review of Initiative Application on Certificate of Need for Long Term Nursing Home and Residential Psychiatric Treatment Centers

I. INTRODUCTION AND SUMMARY

You have asked us to review an application for an initiative petition entitled "An Act amending the certificate of need requirement to apply only to facilities providing long term nursing home beds and residential psychiatric treatment centers." We have completed our review and find that the application complies with the constitutional and statutory provisions governing the use of the initiative. Under these circumstances we recommend that you certify the application.

II. SUMMARY OF THE PROPOSED BILL AND ANALYSIS

A. SUMMARY

Current law requires that expenditure of more than $1 million for the construction of a health care facility, alteration of the bed capacity of a health care facility, or expanding a health care facility to provide a new category of health services must be preceded by the issuance of a certificate of need from the Department of Health and Social Services. *See* AS 18.07.031(a). In addition, this law requires a certificate of need from the Department before a building can be converted to a licensed nursing home. AS 18.07.031(b). For a discussion of the background of the certificate of need program, please *see* 2005 Inf. Op. Att'y Gen. 2 (Oct. 12; 663-06-0049).

This bill would eliminate certificate of need requirements for all facilities except "a long-term nursing home or a facility providing nursing home beds or a residential

psychiatric treatment facility."[1] We note that the title of the bill uses somewhat different terms than the text of the proposed bill. The title refers to "residential psychiatric treatment centers," while the text of the bill amending AS 18.07.111(8) refers to "a residential psychiatric treatment facility." Similarly, the title of the bill refers to "facilities providing long term nursing home beds," while the bill's text in the proposed amendment to AS 18.07.111(8) refers to "a long-term nursing home or a facility providing nursing home beds." The Department of Health and Social Services indicates that it is extremely careful in defining the term "nursing home facility" because these facilities are subject to specific requirements in order to receive Medicaid reimbursement. The proposed bill's imprecision in drafting may raise issues regarding implementation of the bill if it is enacted. However, imprecision in drafting is not a ground for rejection of an initiative application. *See* 1991 Inf. Op. Att'y Gen. at 5 (Jan. 1; 663-90-0141).

The proposed bill is very different from the bill proposed by an initiative application submitted by these sponsors earlier this year addressing certificate of need. Our office reviewed the earlier initiative application in 2005 Inf. Op. Att'y Gen. (Oct. 12; 663-06-0049). In our earlier opinion we recommended that you deny certification because the proposed bill included prohibited local and special legislation. The bill proposed by the earlier initiative application would have eliminated the certificate of need requirements for urban Alaska, but maintain them in rural Alaska. In our earlier opinion we suggested that the sponsors could avoid the local and special legislation issue in the

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[1] The terms "long term nursing home," and "facility providing nursing home beds" are undefined in AS 18.07.021—AS 18.07.111, and in the bill proposed by this initiative application. However, "nursing home bed" is defined in AS 18.07.111(9) as "a bed not used for acute care in which nursing care and related medical services are provided over a period of 24 hours a day to individuals admitted to the health care facility because of illness, disease, or physical infirmity. "Residential psychiatric treatment center" is defined in AS 18.07.111(10) as

> a secure or semi-secure psychiatric facility or inpatient program in a psychiatric facility that is licensed by the Department of Health and Social Services and that provides therapeutically appropriate and medically necessary diagnostic, evaluation, and treatment services.
>
> (A) 24 hours a day for children with severe emotional or behavioral disorders;
>
> (B) Under the direction of a physician; and
>
> (C) Under a professionally developed and supervised individual plan of care designed to achieve the recipient's discharge from inpatient status at the earliest possible time that is intensively and collaboratively delivered by an interdisciplinary team involving medical, mental health, education, and social service components.

bill by eliminating certain categories of facilities from the certificate of need statute. *Id.* at 4. The sponsors have changed the proposed bill so that it no longer eliminates the certificate of need requirement for urban Alaska while retaining the requirement for rural Alaska. Instead, the proposed bill now requires a certificate of need for certain types of health care facilities, and eliminates the requirement for other types of facilities. By making this change the sponsors have eliminated the "local and special legislation" problem in the current application. Under the current bill, hospitals, facilities for independent diagnostic testing, kidney disease treatment, intermediate care, and ambulatory surgery would no longer be subject to the certificate of need requirement.

The bill proposed in the current application contains a number of introductory clauses indicating that the certificate of need requirement limits medical choices and prevents competitive, lower prices for health care costs. The last of these "whereas" clauses indicates that a majority of states either have no certificate of need regulations or limit regulation to long term nursing home beds to help control government costs. The bill then sets out a very brief description of proposed revisions to the certificate of need statutes, repealing AS 18.07.041, revising the definition of "health care facility" set out in AS 18.07.111, and directing that conforming amendments be made to Title 18, Chapter 7, to reflect the changes in the definition of health care facility. The new definition for "health care facility" set out in proposed AS 18.07.111(8), is "a long-term nursing home or a facility providing nursing home beds or a residential psychiatric treatment facility."

B. ANALYSIS.

Under AS 15.45.070, the lieutenant governor is required to review an application for a proposed initiative and either "certify it or notify the initiative committee of the grounds for denial." The grounds for denial of an application are that (1) the proposed bill is not in the required form; (2) the application is not substantially in the required form; or (3) there is an insufficient number of qualified sponsors. AS 15.45.080. We discuss these next.

1. The Form of the Proposed Bill

The form of a proposed initiative bill is prescribed by AS 15.45.040, which requires that (1) the bill be confined to one subject; (2) the subject be expressed in the title; (3) the enacting clause state, "Be it enacted by the People of the State of Alaska"; and (4) the bill not include prohibited subjects. The prohibited subjects—dedication of revenue, appropriations, the creation of courts or the definition of their jurisdiction, rules of court, and local or special legislation—are listed in AS 15.45.010 and in article XI, section 7 of the Alaska Constitution.

The bill is confined to one subject: certificate of need requirements for nursing home and psychiatric facilities. The subject of the bill is expressed in the title. The enacting clause is set forth correctly. The proposed bill does not contain a prohibited subject. As we explained above, the current bill does not limit application of the certificate of need requirement to rural Alaska, and instead limits the certificate of need requirement to certain types of health care facilities, while eliminating the requirement for other types of facilities. Therefore, the bill no longer contains prohibited local and special legislation. Accordingly, the bill is in the required form.

2. The Form of the Application

The form of an initiative application is prescribed in AS 15.45.030, which provides:

> The application shall include (1) the proposed bill to be initiated, (2) a statement that the sponsors are qualified voters who signed the application with the proposed bill attached, (3) the designation of an initiative committee of three sponsors who shall represent all sponsors and subscribers in matters relating to the initiative, and (4) the signatures and addresses of not less than 100 qualified voters.

The application meets the first three requirements. With respect to the fourth requirement, the Division of Elections within your office determines whether the application contains the signatures and addresses of not less than 100 qualified voters.

3. Number of Qualified Sponsors

As noted above, the Division of Elections within your office will determine whether there are a sufficient number of qualified sponsors.

III. PROPOSED BALLOT AND PETITION SUMMARY

We have prepared the following ballot-ready petition summary and title for your consideration:

Limit Certificate of Need Requirement

> This bill would amend the law that requires a person to obtain a certificate of need from the state before a health care facility

BE IT ENACTED BY THE PEOPLE OF ALASKA

The Consumer's Access to Competitive Health Care Act

" An Act amending the certificate of need requirement to apply only to facilities providing long term nursing home beds and residential psychiatric treatment centers."

Whereas: high and ever-rising health care costs are hurting Alaskan families, raising workers' compensation costs, putting health care insurance out of economic range for individuals and companies, and raising Medicaid and Medicare costs throughout Alaska;

And whereas: it is an accepted premise that competition brings higher quality services and lower prices to consumers;

And whereas: Alaska's certificate of need program needlessly limits medical choices for Alaskans and prevents competitive, lower prices for Alaskans through prohibitive government regulation;

And whereas: the US Departmen. of Justice and Federal Trade Commission have both identified certificate of need regulations as a major driver of rising health care costs in the United States for the states that maintain these regulations;

And whereas: a majority of states in the United States either have no certificate of need regulations or limit them only to long-term nursing home beds to help control government costs;

Therefore, be it enacted by the People of Alaska:

Repeal 18.07.041 Standard of Review for Applications for Certificates of Need Relating to non-nursing Home beds and Services.

Section 18.07.111 Definitions is amended to read:

> (8) "health care facility" means a long-term nursing home or a facility providing nursing home beds or a residential psychiatric treatment facility.

Title 18 Chapter 7 Certificate on Need is further amended to provide conforming amendments to reflect the changes in the definition of health care facility.

CERTIFICATE

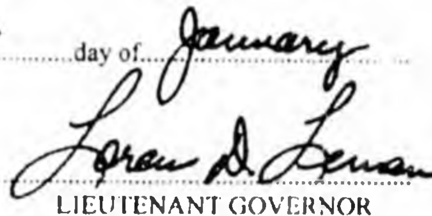
I LOREN LEMAN, LIEUTENANT GOVERNOR FOR THE STATE OF ALASKA, CERTIFY THAT the initiative application for, "An Act amending the certificate of need requirement to apply only to facilities providing long term nursing home beds and residential psychiatric treatment centers," has been reviewed and is in proper form as required under the provisions of Article XI of the Constitution of the State of Alaska and the provisions of AS 15.45.010 through AS 15.45.070.

I FURTHER CERTIFY THAT the application contained the signature and addresses of at least 100 qualified voters.

IN TESTIMONY OF THIS, I have signed this document and affixed the Seal of the State of Alaska, at Juneau Alaska,

This 17th day of January

A.D. 2006



LIEUTENANT GOVERNOR

The initiative must be filed within one year from the date notice is given that the petition booklets are ready for delivery (AS 15.45.140). However, you should also be aware of the time requirements provided in AS 15.45.190 (copy enclosed). The petition must be signed by qualified voters at least equal in number to 10 percent of those who voted in the last General Election, who are resident in at least three-fourths of the House districts of the State and who, in each of these House districts, are equal in number to at least seven percent of those who voted in the preceding General Election in the House district.

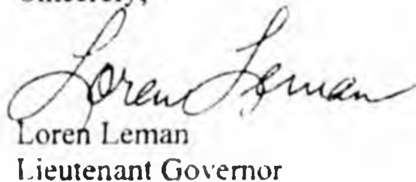
The number of signatures that you need to gather will be based on the 2004 General Election (6 AAC 25.240 (i)). You will need at least 31,451 qualified voters in at least 30 election districts to sign the petition. The vote totals for each House district from the 2004 General Election are enclosed.

This is the first initiative subject to the requirements of HB 94, which had an effective date of September 22, 2005. HB 94 (FSSLA 2) requires the Division of Elections to estimate the cost to process and review each initiative, and each affected department to estimate the minimum costs to the State associated with the initiative.

The Department of Health and Social Services estimates that this change could allow health care construction capital expenditures of up to $373.4 million to be built without review by the Department. This could increase Medicaid costs by up to $41.2 million annually, of which $20.6 million would be State General Funds, for operations and depreciation expense under the current Medicaid rate-setting statutory and regulatory process. This estimate does not include potential increases in costs to the general public related to facilities raising prices because of under-utilization, or the potential for facilities in small markets to request exceptional relief if they experience financial difficulties. The Division of Elections estimates it will cost $39,800 to review and process this initiative.

If you have questions or comments about the initiative application certification, please contact my special assistant, Lauren Yocom, at 465-4082.

Sincerely,



Loren Leman
Lieutenant Governor

Enclosures

cc: Representative Vic Kohring, Initiative Committee Member
Representative Bob Lynn, Initiative Committee Member
Michael Barnhill, Assistant Attorney General, Department of Law
Whitney Brewster, Director, Division of Elections

State Capitol
Juneau, Alaska 99801
907.465.3520 465.5400 FAX
www.ltgov.state.ak.us

550 West 7th Ave, Suite 1700
Anchorage, Alaska 99501
907.269.7460 269.0263 FAX
Lt_Governor@gov.state.ak.us

Lieutenant Governor Loren Leman

January 17, 2006

Mr. Paul Fuhs
329 E 10th Ave
Anchorage, AK 99501

Dear Mr. Fuhs:

You submitted to me an initiative application for a bill entitled, "An Act amending the certificate of need requirement to apply only to facilities providing long term nursing home beds and residential psychiatric treatment centers," for review under AS 15.45.070. I forwarded it to the Division of Elections for verification of signatures and the Department of Law for legal review.

The petition statistics report prepared by the Division of Elections and the Department of Law's opinion regarding your application are enclosed.

The Division of Elections verifies that your application has a sufficient number of sponsors to qualify for circulation of a petition. The Department of Law concludes that the initiative application complies with AS 15.45.030 and AS 15.45.040. Consequently, I certify your initiative application as being in the proper form under the provisions of AS 15.45.010 through AS 15.45.070, and Article XI of the Alaska Constitution. Your official certificate is enclosed.

As Lieutenant Governor and in accordance with AS 15.45.090 (2), it is my duty to prepare an impartial summary for the petition booklets. The following is the petition summary I propose:

Limit Certificate of Need Requirement

> This bill would amend the law that requires a person to obtain a certificate of need from the state before a health care facility can be built. It would remove certain facilities from the requirement. A certificate of need would no longer be required for new hospitals or facilities for diagnostic testing, treatment of kidney disease and day surgery. A certificate of need would still be required for long-term nursing care and residential psychiatric treatment care facilities.
>
> Should this initiative become law?

The Division of Elections will prepare and print numbered petition booklets for circulation. As soon as the booklets are available, the Division will send them to the Division's regional office of your choice (Juneau, Anchorage, Fairbanks or Nome). At that time, you will also be provided with instructions for booklet distribution and accounting. These must be followed.

can be built. It would remove certain facilities from the requirement. A certificate of need would no longer be required for new hospitals or facilities for diagnostic testing, treatment of kidney disease and day surgery. A certificate of need would still be required for long-term nursing care and residential psychiatric treatment care facilities.

Should this initiative become law?

This summary has a Flesch test score of 41.702, which is lower than the target readability score of 60. However, given the need to use technical and multi-syllable words in the summary, we have made the ballot summary as readable as is possible. Given these circumstances, we believe that the summary meets the readability standards of AS 15.60.005.

IV. CONCLUSION

Assuming that the Division of Elections determines that there are a sufficient number of qualified subscribers, we conclude that this bill and application are in the proper form, and that the application complies with the constitutional and statutory provisions governing the use of the initiative. Therefore, we recommend that you certify this initiative application, and so notify the initiative committee. Preparation of the petitions may then commence in accordance with AS 15.45.090.

Please contact me if we can be of further assistance to you on this matter.

SJF/mi

cc: Whitney Brewster, Director
Office of Lieutenant Governor, Division of Elections

Stacie Kraly, Chief Assistant Attorney General
Department of Law, Human Services Section

1917 Abbott Road, Suite 100
Anchorage, AK 99507
(907) 278-2741phone
(907) 743-8284 fax

Grant T. Roderer, M.D. · Lawrence W. Stinson, M.D. · Jimmy M.Tamai, M.D.
Gregory R. Polston, M.D. · Nancy E. Cross, M.D. · Marc Slonimski, M.D.
Rafael L. Prieto, M.D. · Richard Cobden, M.D. · Deborah Kiley, ANP
Lois Michaud, Ph.D. · Connie Judd, ANP · Catherine Barrett, ANP

FACSIMILE TRANSMITTAL

To: HESS Committee Fax: (907) 465-3175

Company: Phone:

From: Shauna Baughcum, Corporate Administrator Date: 3-28-06

Re: Pages: 22 (including cover sheet)

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please call to confirm receipt ☐ Please reply

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John Barnes, Policy Analyst
jbarnes@washingtonpolicy.org

Concerns regarding the fiscal note for Alaska's HB 287 (2006)

Scaling Down Certificate of Need Requirements

- Too little explanation of the fiscal note estimates. How *exactly* did they arrive at these numbers? This is especially important if the crux of the argument against scaling down CON laws is the fiscal impact on the state.

- The department predicts $2.7 million in expenditures for Cardiac Hospitals starting in FY2010, but admits there have not been any specific inquiries for such facilities.

- The department admits uncertainty with the numbers for various reasons, but insists their estimates are "conservative." This does not make sense. If this is true uncertainty, then their estimates could be high as well.

- In general, the department makes estimates and projections for several years down the road. You cannot assume this to be accurate. Financial estimates for that far out are laden with problems because of shifting variables and unpredictable circumstances. The general unreliability of state projections and projection methodologies is a large reason why CON laws do not help control health care costs. You cannot centrally-plan for the present or the near future, much less 6 or 7 years down the road.

- The department makes a $2.7 million projection for Orthopedic Hospitals without providing demonstration of interest. They state simply that "it is only a matter of time before they move to Alaska," and make a projection for FY2012. Fiscal notes ought not be based on the *supposed* inevitability of anything, and a projection for 6 or 7 years down the road is informed speculation at best due to shifting economic and demographic factors.

- In general, the calculation methodology (that which can be seen, at any rate) is suspect. The department is basing its estimation of facilities that would be built in a post-CON era on letters of intent and applications received in the past. But letters and applications are filed with the understanding that CON may not be granted. They are filed in an attempt to enter a market where providers are insulated from competition, where success is much more assured. When there is no CON barrier, providers have to be more careful in deciding to enter the market, and some who filed letters and applications would not actually proceed with projects because the likelihood for success changed. **You cannot assume that the number of letters and applications reflect the likely number of new facilities.**

- The fiscal note is based on the *assumption* that a massive supply surge will follow a CON downscaling. That is not necessarily true. A 1998 empirical study published in *Journal of Health Politics, Policy, and Law* examined health spending between the late 1970s and 1993

and found that in states that repealed CON laws, there was no surge in health spending.[1] This evidence contradicts the fiscal note's projections. [If this surge does occur, it will reflect the fact that the supply was abnormally depressed due to CON in the first place. In the long run Alaska will experience a leveling off of supply that reflects true demand.]

- A 2003 study by three leading authorities in the field of health policy found that aggregate state-level data from 1981 through 1998 shows states that repealed their CON and moratorium laws had no significant growth in either nursing home or long-term care Medicaid expenditures.[2] This evidence contradicts the fiscal note's projections, and *even if these facilities are not included in the bill, this evidence calls into question the department's methodology for fiscal impact and its assumptions in general.*

- Fiscal note numbers do not reflect the potential for cost reduction in the aftermath of CON downscaling. CON laws curtail services and facilities, often forcing patients into more expensive substitutes, thus increasing costs for patients or third-party payers. EXAMPLE: if nursing home beds are not available, the discharge of patients from more expensive hospital beds may be delayed or patients may be forced to use a more expensive nursing home.

- Fiscal note numbers do not take into account the potential for savings through reduced administrative costs, less personnel time, etc. If less time and resources are being spent running CON, that's money saved. This is true for business as well. Many businesses have entire departments devoted to just the CON process.

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[1] Christopher Conover and Frank Sloan. "Does removing certificate-of-need regulations lead to a surge in health care spending?" *Journal of Health Politics, Policy, and Law*, Vol. 23, Issue 3.

[2] David C. Grabowski, Robert L. Ohsfeldt, and Michael A. Morrisey. "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures," *Inquiry* 40 (Summer 2003): 146-157.

BEYOND HEALTH CARE REFORM: RECONSIDERING CERTIFICATE OF NEED LAWS IN A MANAGED COMPETITION SYSTEM

PATRICK JOHN MCGINLEY[*]

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I. INTRODUCTION

America is spending nearly a trillion dollars annually on health care.[1] Although neither state nor national legislators can agree on the details, the focus of health care reform has been the "managed competition" model. Managed competition intends to control health care costs by encouraging price competition among health care providers.[2] In a typical managed competition plan, such as that recently enacted in the state of Florida, a state agency negotiates on behalf of many purchasers in order to demand lower prices from providers.[3] Managed competition, therefore, attempts to lower costs by managing demand.

Supply, and not demand, was the emphasis of early health care regulation.[4] "Certificate of need" (CON) laws were designed to keep health care costs low by requiring advance approval by state agencies for most hospital expansions and major equipment purchases.[5] Congress required all states to pass CON laws in 1974, but quickly repealed that requirement after finding it ineffective for controlling health care costs.[6]

Today, thirty-eight states retain CON laws.[7] Many of these same states have passed managed competition laws.[8] This Comment will explore the role of CON laws in a state with a managed competition system.[9] Part II traces the origin and intent of CON, noting that CON has historically failed to achieve its intended policy goals.[10] Part III summarizes the origin and implementation of a managed competition health care strategy, illustrating that strong evidence demonstrates that managed competition can lower health care costs.[11] Part IV shows that managed competition invalidates the presumptions underlying the alleged need for CON.[12] Part V focuses on Florida, where the conflict between CON and managed competition is becoming reality, and urges Florida and similarly situated states either to scale back CON or accept the failure of managed competition that CON will inevitably cause.[13]

II. ORIGIN AND INTENT OF CERTIFICATE OF NEED REGULATIONS

Certificate of need is the common name for a diverse group of state health care laws attempting to control health care costs by regulating supply.[14] These laws require that a permit, usually called a certificate of need, be issued by a state health planning agency before a health care facility may construct or expand, offer a new service, or purchase equipment exceeding a certain cost.[15] A CON will not be issued unless a new facility or service is genuinely needed in a given community.[16] Although determining need can be problematic,[17] CON laws provide statutory and rule criteria to guide the issuing agency's discretion.[18]

A. State Origins

CON laws originated from local community efforts to allocate philanthropic and federal funding so that new hospitals would be built where they were most needed.[19] Throughout the Great Depression and World War II, few new hospitals were built in the United States, yet many existing hospitals became obsolete.[20] The ensuing crisis was exacerbated by an inadequate distribution of hospitals among and within the states.[21] In response, community fund-raising and charitable activities of the 1940's evolved into organized community plans for hospital development.[22] Community planning became particularly important in 1946 with the passage of the federal Hill-Burton Act.[23] Hill-Burton provided federal subsidies for hospital construction, and promoted local planning in order to identify local needs.[24] The local planners in some communities worked under nongovernmental auspices, while planners

in other communities worked as part of governmental health planning agencies.[25] For those communities without government-enforced health planning agencies, local plans were voluntary.[26]

Over time, voluntary planning waned, while compulsory, government-enforced planning flourished.[27] This was not necessarily the result of the Hill-Burton Act, because eighty-seven percent of the total funds required for voluntary hospital construction from 1946 to 1967 came from private fund-raising sources.[28] One explanation for why voluntary planning declined is the benefit that the hospitals received from mandatory regulation.[29] Mandatory regulation through health planning agencies helped identify the most urgent health needs, helped meet these needs through cooperative and consensual development, and helped curb the excessive cost increases and price decreases often caused by a competitive marketplace.[30]

Hospitals regulated by a health planning agency can collectively determine the size of a community's hospital bed supply, and thereby engage in output restriction.[31] Regulated hospitals can also collectively allocate areas of responsibility both geographically and by activity, and thereby engage in market division.[32]

These two activities—output restriction and market division—are classic characteristics of a cartel.[33] In fact, many of the output restriction and market division activities of early health planning agencies were indistinguishable from the activities of a cartel.[34] Critics frequently observe that "regulatory agencies tend to adopt strategies disturbingly similar to those which an industry-wide cartel . . . would pursue if it could."[35] In any cartel, centralized planning and sanctions against uncooperative members are essential if the participants are to avoid the effects of a competitive market.[36] The early mandatory health planning agencies provided the necessary planning and sanctions, and did so with the aid and permission of local governments.[37]

Hospitals have successfully organized to support and proliferate state CON laws. In 1964, New York became the first state to pass a statute of statewide effect[38] that required a governmental determination of need before any hospital or nursing home was constructed.[39] Just four years later, the American Hospital Association indicated its membership's acceptance of CON laws.[40] The American Hospital Association then began nationwide lobbying efforts to pass CON laws at the state level,[41] and even drafted a model state law.[42] By 1975, twenty states enacted CON laws.[43] By 1978, thirty-six states had enacted such laws.[44]

B. Congressional Origins

After 1978, almost all states enacted CON laws, primarily because the National Health Planning and Resources Development Act of 1974[45] provided substantial federal funding for state and local health planning activities.[46] Under the 1974 National Health Act,[47] certain federal health care funds were conditioned on the state's enactment of CON laws.[48] By 1986, forty-two states plus the District of Columbia had responded to Congressional pressure by enacting a CON program.[49] After 1986, however, Congress turned full circle, repealing the 1974 National Health Act and its requirement for state CON laws.[50] The reason for Congress' abandonment of CON is simple: the laws are counterproductive for reforming health care.

1. Why Congress Promoted Certificate of Need: The Legislative History

CON laws were expected to add "teeth" to the 1974 National Health Act.[51] Under the Act, Congress intended CON to achieve three health care goals. First and foremost, CON was to restrain skyrocketing health care costs.[52] Second, CON was to prevent the unnecessary duplication of health resources.[53]

Third and most ambitiously, CON was to achieve equal access to quality health care at a reasonable cost.[54] The legislative history of the National Health Act clearly enunciates these goals, yet does not clearly illuminate the social and economic situation which made these goals appear acceptable and necessary. The following addresses each of these legislative goals separately, supplementing each with information gathered from legal sources published at the time the Act was passed, or published after the Act with the intent of analyzing the Act's purpose. Through such an analysis, Congress's "three" reasons for CON are revealed to be just a single purpose: to reduce the aggregate cost of the nation's health care.

a. Restraining Skyrocketing Health Care Costs

The primary Congressional purpose in requiring CON laws was to save money.[55] Statistics compiled prior to the passage of the 1974 Act reveal the severity of the 1970s' health care crisis. For example, when Congress considered the National Health Act, medical care prices were rising at an annual rate of 16.6 percent,[56] hospital charges were rising at an annual rate of 18.7 percent,[57] yet the consumer price index was rising at a considerably lower annual rate of 13.7 percent.[58] The average cost of a single day in the hospital rose from nearly $16.00 in 1950, to almost $45.00 in 1965, and then to about $128.00 in 1974.[59] These figures show an alarming rate of increase in health care costs. At the time of the 1974 Act, as now, health care costs were out of control.[60]

b. Preventing the Unnecessary Duplication of Health Resources

The drafters of the 1974 National Health Act viewed the underutilization of health care resources as a primary cause of skyrocketing health care costs.[61] The 1974 National Health Act was "premised on the theory that the current structure and incentives of the health care industry lead to overinvestment and that unneeded . . . health care resources contribute significantly to rampant inflation in health care costs."[62]

The Senate committee drafting the 1974 National Health Act found that the need for additional hospital beds[63] in the nation had virtually disappeared.[64] As of 1974, 20,000 beds nationwide were underutilized to the point of being labeled "surplus," and the number of surplus beds was expected to exceed 67,000 by 1975.[65] Accordingly, the Act sought to remedy the "maldistribution of health care facilities and manpower."[66]

Congress adhered to the theory that the cost of excess supply was ultimately borne by third party purchasers, and then passed on to health care consumers in the form of higher premiums and cost for services.[67] According to Congress's theory, third party fee-for-service insurance agreements encourage providers to overindulge in capital investments.[68] Companies operating in a traditionally competitive market do not overindulge in capital investments because service and facility expansion benefits a company only if demand exceeds supply, or if efficiencies can be realized through economies of scale.[69] In Congress's theory, however, health care facilities do not respond to these typical pressures of a competitive market. Proponents of CON cite four reasons why health care facilities have the propensity to overinvest in capital investments: the externalization of purchase costs, the nonprice competition among providers, the physicians' effect on supply, and the "Roemer Effect" on demand.[70]

i. The Externalization of Purchase Costs

In the health care climate that created the 1974 Act, third party fee-for-service insurance agreements, such as those traditionally provided by Blue Cross/Blue Shield and the federal Medicare and Medicaid health insurance programs, were the dominant means of health care financing.[71] Third party fee-for-service insurance agreements, or "fee-for-service," reimburse health care providers retrospectively for

the costs of services rendered to insured patients.[72] In other words, fee-for-service agreements do not negotiate medical fees in advance, but instead negotiate payment after services are rendered and prices are set. Fee-for-service reimbursement rates typically include "overhead," such as the operating costs and capital expenditures of health care providers.[73] Congress believed that the overhead payments, although initially made by the third party insurer, are ultimately borne by the public through higher taxes due to Medicare/Medicaid[74] or through higher premiums charged by commercial insurers.[75] Health care facilities are therefore allegedly insufficiently deterred from unnecessary construction,[76] because costs are passed to the consumer in the form of higher fees. As a result, fee-for-service allegedly allows health care entities to overinvest in new facilities and equipment with diminished regard for public need or efficiency.[77]

Therefore, fee-for-service allegedly reduces the financial risks of excess capacity and overinvestment because health care providers directly recoup their investment costs.[78] However, this contention overlooks the monitoring effects of section 1122 review. The 1974 National Health Act's CON program was modeled after the earlier, and coexisting, section 1122 capital expenditure review provisions[79] of the Social Security Amendments of 1972.[80] Even after Congress mandated the passage of state CON laws, Medicare and Medicaid section 1122 reviews were allowing states to review capital expenditures and to deny reimbursement for expenditures which did not fit the state's health plan.[81] Section 1122 programs allow states, on a voluntary basis, to participate in reviewing capital expenditures made by health care facilities receiving federal funds under the Medicare and Medicaid subchapters[82] of the Social Security Act.[83] State planning agencies perform the section 1122 reviews, and may deny federal reimbursement for amounts attributable to depreciation, interest on borrowed funds, and return on equity capital if the agency finds that a health care facility's capital expenditure does not further state health planning needs.[84] Section 1122 review programs therefore sought the same result as CON laws by empowering state agencies to curb health care facility growth and expenditures by requiring conformance with a state health care plan. Stated somewhat differently, section 1122 and CON both seek the same goals using the same methods.

With 20/20 hindsight, it appears Congress was unwise in believing that CON would succeed in adequately controlling health care costs when the section 1122 review programs did not succeed. According to the legislative history, Congress was aware that CON laws achieved a purpose nearly identical to section 1122 review, and achieved this purpose by nearly identical means.[85] Recognizing this, a House of Representatives committee recommended amending the Senate bill so that CON laws would be required only in states which did not voluntarily engage in section 1122 review programs.[86] However, in a Conference Committee, a substitute bill was drafted omitting the House Committee's recommended amendment.[87] Thus, even in states already controlling capital expenditures under section 1122 review programs, CON laws were required[88] under the 1974 National Health Act.[89]

ii. The Non-Price Competition Among Facilities

Congress also believed that health care facilities were not only undaunted from making unnecessary construction and capital expenditures, but were actually *encouraged* to construct and expend by the pressures of non-price competition.[90] Hospitals cannot compete for patients or doctors based on price, so they compete for doctors and patients based on quality.[91] To most, competition based on quality would seem to be an acceptable behavior.[92] To proponents of CON, however, competition based on quality is socially undesirable.

Health care consumers, providers, and hospitals agree that quality means having the biggest, most elaborate, most modern facilities and equipment. "While health care regulators seek to rationalize the health care system, health care consumers want to feel that when family members fall ill, they will have convenient access to the best and most technologically advanced medical care."[93] Patients want to be

treated by hospitals using the latest and best technology and procedures, even if they do not "need" these facilities in the eyes of industry regulators.[94]

Hospitals have four reasons for wanting the best facilities and equipment: a concern for patients, a desire to attract new patients, a desire to attract the best physicians, and a desire "not to be regarded as a second-class institution."[95] The concern for patients is both altruistic and advantageous.[96] The desire to attract new patients is a necessity for the profitable operation of any health care facility.[97] The desire to attract physicians stems from a concern for patient welfare and a concern for the hospital's bottom line.[98] The desire "not to be regarded as a second-class institution" is a product of human vice, which some characterize as "institutional ego."[99] The four factors combine to motivate hospitals to invest, invest, invest. Physicians further fuel the hospitals' quest to invest by demanding the most modern facilities and equipment.[100]

iii. The Physician's Effect on Supply

A health care facility's financial risks from excess capacity and overinvestment are allegedly reduced because the primary decisions concerning health care services are made by the physician and not the ultimate health care consumer.[101] Doctors influence the amount of "services" supplied to a hospital. For example, good evidence exists that the number of surgeries performed is largely determined by the number of physicians available—the more surgeons trained, the more surgery patients supplied.[102] This phenomenon is not limited to surgeons, but extends to all medical professionals who potentially supply patients to a hospital. For example, "if his schedule is light, it is easy for Dr. Smith to tell Ms. Jones to come back every two weeks rather than once a month."[103] The health care system removes the "purchase" decisions from the "invisible hand" of the marketplace, and puts those decisions into the hands of the physician.[104] Physicians have an economic incentive to "sell" their "product," and therefore have a vested interest in generating supply.[105]

iv. The "Roemer Effect" on Demand

Just as physicians can allegedly generate supply, hospitals allegedly generate demand.[106] Statistics show that when more hospital beds are available, more hospital beds will be filled.[107] Likewise, when more physicians are available, more health care services will be used.[108] In short, the effect of excess supply of health services is the "manufacture" of demand.[109] This effect—the "Roemer Effect"—is named after the individual who first noted the relationship.[110]

Hospitals widely accept the statistic that an empty bed costs the hospital about two-thirds as much as an occupied one.[111] Applying this realization, hospitals can assume that a bed should be used if the value of hospitalization to the patient is at least one-third the total cost to the hospital.[112] Economics and social pressures give hospitals the motive and opportunity to generate demand for services.

In sum, Congress adopted the second goal of CON—preventing unnecessary duplication of health care costs—to combat four undesirable factors: the externalization of purchase costs, the non-price competition between facilities, the physician's effect on supply, and the "Roemer Effect" on demand. A closer analysis reveals that each factor is undesirable because each leads to an increase in the nation's health care costs. Therefore, Congress' second goal of CON is only an extension of Congress's first goal—restraining skyrocketing health care costs.

c. Achieving Equal Access to Quality Health Care at a Reasonable Cost

Congress's third goal—achieving equal access to quality health care at a reasonable cost—does not have

a direct connection to restraining costs.[113] Cost concerns were the paramount reason for the 1974 National Health Act's CON requirements, but the Act also intended CON to help achieve equal access to health care.[114]

However, CON was to be only one element in the equation creating equal access to health care; the most significant element was the anticipated passage of a national health insurance program.[115] Medicare, Medicaid, and the expected national insurance program would ensure universal access, and the role of CON laws was to control rising costs before Congress passed a national health insurance plan.[116] Of course, Congress never passed a national health insurance plan.[117] As a result, Congress's third goal was not addressed with any practical application, but was instead little more than lip service to a noble ambition. Therefore, Congress's "three goals" were in fact just one: a goal of reducing the nation's aggregate health care costs.

2. Why Congress Abandoned Certificate of Need: The Legislative Reality

Four years after the enactment of CON, Congress repealed its mandate.[118] Two interrelated concerns spurred the decision—the law failed to reduce the nation's aggregate health care costs, and it was beginning to produce detrimental effects in local communities.

Shortly after CON was mandated to the states, the nation's aggregate health care costs reached an historic high. America's 1982 medical bill reached $332 billion, or 10.5 percent of the gross national product.[119] "This marked the first time the cost of medical services exceeded ten percent of the nation [']s total production."[120] "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."[121] 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.[122] Today, Americans are spending nearly a trillion dollars annually on health care.[123] In searching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering health care costs.[124] CON "has elicited a remarkable evaluative consensus—that it does not work."[125]

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.[126] In Representative Rowland's district:

> [T]he citizens of Putnam County are proud of their 20-year-old community hospital. They built it with local funding, without using any Federal Hill-Burton funds, and they still support it locally. They are proud enough to have recently approved a 1-cent sales tax to renovate the facility. They are not seeking an expansion. The hospital has always had 50 beds, and that's what they propose to maintain.
>
> However, when Putnam County authorities went to the State health planning agency for the required approval under the certificate-of-need program this year, they ran into unexpected trouble. The agency looked over the request for the locally funded hospital improvements and decided to deny it—unless the hospital eliminated ten beds.[127]

Putnam County protested the agency's decision.[128] The county's growth projections indicated that all fifty beds would eventually be needed, even though the hospital was not currently utilizing all of its

beds.[129] Likewise, Putnam County's cost estimations indicated that the decrease in beds would have no significant effect on health care costs.[130] The decrease in beds "would, however, reduce the number of nursing students who could be enrolled in the hospital's LPN program at a time when the country has a critical shortage of nurses. And it would be much more costly when the county has to add back those 10 beds."[131]

Nevertheless, the state CON agency would not acknowledge the long-term increase in cost caused by having "to add back those 10 beds," nor would the agency consider the long-term impact on the nation's shortage of nurses which could be exacerbated by eliminating Putnam County's ability to train licensed practicing nurses.[132] "Eliminating the beds would, however, enable the State health planning agency to get the number [of beds] more in line with . . . the [regional] quota . . . [I]t's a classic case of a [bureaucracy] paying more attention to numbers on a piece of paper than to reality."[133] The reality, according to Representative Rowland, was "the harmful impact this would have on the community without doing anything significant to cut costs."[134] Representative Rowland did not blame the bureaucrats for these ill effects, but rather blamed the CON laws that necessitated such bureaucracy:

> Although I believe the people at the State health planning agency are sincere, I also recognize they are tied to a system that is often high-handed and arrogant. Federal funding for certificate-of-need programs was ended in 1987, and 12 States have now abandoned the program altogether. It's now time to abolish it throughout the Nation. If anyone wants to know why, just ask the people of Putnam County.[135]

C. *The Perseverance of Certificate of Need*

After repealing the 1974 National Health Act and its CON requirements, Congress did not "abolish [CON] throughout the Nation"[136] as Representative Rowland urged. Congress only repealed the legislation mandating state CON laws.[137] States were free to continue regulating health care facilities with CON even after Congress repealed its mandate.[138] Many states did.[139]

One may question the wisdom of continuing any form of state regulation that failed to produce its desired goal when implemented nationwide.[140] 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.[141] 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.[142] These justifications should therefore carry little weight in a proper analysis.[143]

Even though CON perseveres, the rationale supporting CON has disappeared. The logic of CON was based on the health care marketplace as it existed in the 1950s through the early 1970s. Today's medical marketplace is significantly different. CON is predicated on a medical marketplace dominated by third party fee-for-service agreements. However, the modern medical marketplace is shifting away from fee-for-service. The institutions who are the primary purchasers of health care services are banding together with the aid of governments.[144]

III. ORIGIN AND INTENT OF THE MANAGED COMPETITION HEALTH CARE STRATEGY

A governmental system fostering alliances between health care purchasers in order to manipulate the price of health care suppliers is called a managed competition plan.[145] Under managed competition,

governments aid purchasers in negotiating the lowest price for health care.[146] However, the effectiveness of a group of purchasers is greatly lessened when they cannot negotiate against a single hospital, but rather must negotiate with a legalized cartel of hospitals, as is the result under a CON system. The following section suggests that managed competition is doomed to failure unless CON laws are repealed or dramatically scaled back.

Many states are now grappling with the dilemma of meshing the two health care strategies: managed competition and CON. Both strategies, it seems, foster the same goals, but differ in the means used to achieve these goals. Whereas CON attempts to control the marketplace by regulating supply, managed competition aspires to influence prices by putting purchasers on an equal playing field with their organized adversaries.

Like CON laws which evolved from philanthropic activities supported by special interest groups,[147] managed competition laws evolved from the ideas of academicians and were adopted by special interests.[148] Professor Alain Enthoven, of the Stanford University Graduate School of Business, first devised managed competition as an approach to health care reform in the late 1970s.[149] The Enthoven model was further refined by the Jackson Hole Group,[150] and has become the leading model for a managed competition health care delivery system.[151]

The managed competition strategy proposes a scheme of private insurance plans presenting individuals with a range of enrollment options offered by companies which manage the selection process and make individuals pay the difference in price among the insurance options chosen.[152] Legislation dictates what kinds of health plans will be available, therefore creating uniform health care products from which to choose. A separate government entity assumes the task of aggregating health care purchasers, and negotiates on their behalf with providers to purchase the necessary health care products at the lowest possible price.[153] "Managed competition attempts to achieve universal health insurance coverage and health care cost containment via a hybrid between the opposite extremes of a completely socialized system of health insurance like Canada's, and a largely unregulated private insurance market such as currently exists in the United States."[154] This "hybrid" intends to be an enhancement of the existing market system that will "preserve and improve the benefits of competition without sacrificing the social objective[s]."[155]

Managed competition, therefore, uses government regulators to ally health care purchasers in order to negotiate better prices from health care providers.[156] The classic structure of managed competition combines government action in the form of health boards[157] and health alliances[158] with private free-market activity in the form of private health plans.[159] The critical factor of managed competition is that market forces, and not regulatory forces, determine the cost of health care.[160] Government's role in the managed competition strategy is that of organizer and motivator.

A. Governmental Health Boards and Alliances

Through governmental health boards, regulators would set broad guidelines and enforcement standards [161] and stimulate collaboration among purchasers, patients, and the government.[162] Governmental health boards would achieve these goals by selecting the individual health plans offered to health care consumers.[163] In essence, the health board would set broad policy, and implement that policy by regulating the forms of health insurance available in the marketplace.[164]

Through health alliances, the government would attempt to empower the disadvantaged to become players in the free market for health care. Alliances "would have the authority to set global budgets, exclude health plans, and negotiate rates."[165] Alliances function by amassing the purchasing power of

a multitude of health care purchasers, and negotiating on their behalf in order to demand the lowest prices from providers.[166] A governmental health alliance's goal is to bring the purchasing power of larger businesses to the small business community and to individuals.[167]

B. Private Health Plans

Under managed competition, governmental health boards would approve insurance plans that "employ financial incentives and managed care techniques to deliver a more economical and efficient package of health care benefits."[168] Such plans would be offered by private insurance companies.[169] Examples of acceptable plans are the Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) offered by the leading health care insurers.[170]

An HMO is a type of managed care company that provides comprehensive health care coverage for a fixed price to a specific group.[171] HMOs negotiate discounted charges with health care providers, and restrict members to using only that network of providers.[172] HMOs typically refuse to pay for the medical bills of a member who does not use a network provider.[173] In this way, HMOs greatly reduce the consumer's cost of health care.[174]

A PPO is another type of managed care company, similar to an HMO, providing comprehensive health care coverage to a specific group.[175] The primary difference between an HMO and a PPO is that a PPO will allow members to see a doctor outside of its network of physicians, but will not pay so much of the cost as it would if the member saw one of the doctors in the network.[176] HMOs, PPOs, and their hybrid forms[177] can be referred to generally as managed care companies, all of which play a managerial role under a managed competition health care plan.[178]

Managed care and managed competition are not synonymous.[179] Managed competition refers to the overall market structure, including government involvement.[180] Managed care refers to a private association of health care providers who collectively bargain for the use of their services.[181] The collective services of such providers are referred to as integrated delivery systems.[182] These systems are more than vertical integration and joint ventures—they cover a broad range of services, including a full array of hospital and physician services in both inpatient and outpatient settings.[183] They may also include long-term care facilities and specialized services such as mental health or physical therapy.[184] The managed care company and integrated delivery systems are a new form of provider,[185] created in response to the difficulty of individual providers to prosper in the new health care marketplace.

Although managed competition appears promising, no hard evidence unequivocally proves that managed competition is effective.[186] "Managed competition is a controversial public policy that is still being debated, even as it is taking hold of the health care delivery system."[187] One United States Congressman has referred to managed competition as a "fairy tale," while another likened it to the "Star Wars" defense initiative.[188] Even the Congressional Budget Office declared managed competition to be "untried."[189] These concerns about the viability of managed competition are not ill-founded, considering the fact that no nation or state has yet fully implemented a managed competition system.[190] Even the Jackson Hole Group admits that managed competition proposals seem stymied by the inability to predict the economic consequences of their implementation.[191]

States are nonetheless wagering that managed competition will succeed,[192] and commentators are predicting that the proliferation of managed competition is inevitable.[193] The following question is therefore appropriate: what role should CON laws play in a managed competition state?

IV. WHY CERTIFICATE OF NEED IS NOT NEEDED UNDER MANAGED COMPETITION

Unfortunately, in states implementing CON, managed competition will fail. In the words of one commentator:

> [With the proliferation of] certificate-of-need laws . . . an unexpected consequence may follow—a severe restriction of competition in the health care market. [CON laws are] cost-containing only if the excluded providers would have relied on fee-for-service, cost-based, retrospective reimbursement. Prepaid medical group practices or Health Maintenance Organizations (HMOs), however, operate under entirely different rate structures and payment mechanisms . . . . [R]educing [the HMOs'] ability to enter the market or to expand may contribute to higher health care costs. 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, making it impossible for the HMO to develop or expand . . . . [C] ertificate-of-need laws will continue to raise health care costs by restricting the entry of cost-effective providers into the market.[194]

This commentator is illustrating a stark reality of managed competition—it can succeed only if health care providers are forced to negotiate lower consumer prices with health care alliances.[195] CON laws shelter health care providers from the price-cutting demands of health care alliances.[196] "Strength in numbers,"[197] the very reason why a managed competition health care strategy is touted to succeed, would be thwarted by hospital cartels united under CON laws. If HMOs and other managed care companies can be forced from the marketplace by united hospitals, then managed competition will fail.

Instead of risking the failure of the managed competition health care strategy, states should repeal CON laws.[198] Managed competition serves as a "nail in the coffin" of CON by making obsolete the rationale and reasons for CON.[199] Below, each of Congress's reasons for promoting CON is addressed, and shown to be moot under a managed competition health care strategy.

A. Managed Competition Market Incentives Can Adequately Restrain Health Care Costs

Congress's first reason for promoting CON was to address a perceived inability of the health care marketplace to adequately restrain health care costs.[200] However, a managed competition health care marketplace would keep a keen eye on health care spending. For example, many HMOs and managed care companies restrain health care costs by using the Health Plan Employer Data and Information Set (HEDIS).[201] HEDIS is used by HMOs as a performance measurement to give a numerical answer to questions about how well a given health plan serves its members.[202] Inefficient health plans are replaced by more efficient plans.[203]

As well as monitoring HEDIS, managed care companies also monitor "outcomes."[204] "Outcomes" are a measurement of the effectiveness of medical treatments, judged against factors such as mortality and cost.[205] By monitoring outcomes, managed care companies are creating a health care marketplace which seeks to restrain health care costs.

A third and vitally important feature of managed competition that makes the marketplace more responsive to health care costs is managed competition's abandonment of the third party fee-for-service system. Whereas fee-for-service involves individualized payments for each health care service,[206] managed care companies negotiate service discounts in exchange for sending patient volume to providers.[207] The result is the demise of traditional indemnity insurance, in which companies pay whatever rate a health care provider may ask.[208] Instead, health care providers receive a previously

arranged maximum fee for the service performed, and the health care consumer saves money.

Fourth and finally, managed competition gives government, in its role of health care board and health care alliance, the ability to stack the deck in favor of restraint on health care costs. Health care alliances will have the authority to set global budgets,[209] and thereby impose self-restraint on providers who realize that a finite amount of resources will be allocated to their reimbursement. A health care alliance which perceives health care costs to be increasing at too great a rate can thwart that trend by "tightening the money supply"[210] and decreasing the aggregate amount of revenue available to providers. Should a given delivery system[211] not respond to an alliance's global budget pressure or otherwise prove too costly, a health care board would have the authority to eliminate the delivery system from the options available to consumers.

B. Managed Competition Market Incentives Can Adequately Prevent the Unnecessary Duplication of Health Resources

Congress's second reason for promoting CON was that health care markets cannot adequately prevent the unnecessary duplication of health resources.[212] Yet, integrated delivery systems and managed care companies like HMOs have the ability to manage health care resources. "HMO development is perhaps the most promising nonregulatory strategy for bringing the excessive use of health care resources under effective control."[213]

Hospitals which are allied with HMOs and other managed care companies should be exempt from CON statutes.[214] Hospitals managed by managed care companies do not face the same incentives for overexpansion that characterize fee-for-service hospitals.[215] Managed care companies pay providers in advance, rather than retrospectively on a cost-reimbursement basis, and thus have "every incentive to conserve their resources and to seek efficiency."[216] Therefore, another presumption of CON—the marketplace's failure to control the unnecessary duplication of health care resources—is not valid under managed competition.

California, Oregon, and Washington have recognized that hospitals controlled by managed care companies should be exempt from CON regulations thwarting facility construction.[217] These states have taken an important and necessary first step toward the success of managed competition. By exempting managed care companies from CON laws, these states recognize that managed competition eliminates the four presumptions underlying the conclusion that the health care marketplace allows for the unnecessary duplication of health care resources.[218] In the following discussion, the four presumptions—the externalization of purchase costs,[219] the non-price competition between facilities,[220] the physician's effect on supply,[221] and the "Roemer Effect" on demand[222]—are demonstrated to be inapplicable in a managed competition system.

1. No Externalization of Purchase Costs

Proponents of CON contend that the health care marketplace results in an externalization of purchase costs because fee-for-service insurers will reimburse for any provided health service.[223] In other words, a patient need not worry about health care costs, because "insurance will cover it."[224] If this externalization of purchase costs was ever a reality,[225] it ceases to be so under a managed competition health care plan. Managed care companies and integrated delivery systems negotiate fees well in advance of service, and often base those fees on local averages obtained using diagnostic-related group formulas.[226] Diagnostic-related group formulas, or DRG formulas, are "classification[s] developed by Medicare a decade ago to determine how much the federal program will pay for inpatient care."[227] DRG formulas provide health care providers with a fixed payment for treating patients, regardless of the

provider's expense in providing the care.[228] Thus, under managed competition, purchase costs are not external, but rather internal.

The latest managed care proposal from the Jackson Hole Group, as well as internalizing purchase costs via managed care companies, further effects an internalization by requiring government to maintain a balanced health care budget.[229] The Jackson Hole Group notes that a managed competition state needs to achieve a predictable and acceptable level of health care spending, and proposes that the most effective method of achieving this goal is to require that health expenditures not grow faster than revenue.[230] As a result, governmental health alliances would be unlikely to pay more for the same services simply so that a provider can be repaid for unnecessary facilities or equipment. The actual use of the facility or equipment would have to pay for itself by attracting new patients or otherwise generating new revenue, because an alliance constrained by a balanced budget would not likely pay increased fees without gaining increased services in return.

2. Non-Price Competition Among Facilities Replaced by Price and Quality Competition

Proponents of CON contend that it is absolutely necessary to prevent non-price competition between health care providers.[231] Under managed competition, non-price competition is nearly eliminated by the use of "gatekeepers."[232] A gatekeeper is an entity employed by a managed care company to ensure that patients do not unnecessarily increase the cost of health care.[233] For example, a gatekeeper may require that a patient first see a primary care physician[234] before visiting a more expensive specialist[235] or seeking tertiary care.[236] All patients must first contact the managed care company's gatekeeper before seeking non-emergency treatment.[237] A patient is thereby precluded from visiting the biggest, most elaborate, most modern facilities when such facilities are not medically necessary.

Furthermore, managed competition fosters sharp price competition between health care providers. In fact, critics of managed competition note that health care providers in a managed competition environment can compete on few terms other than price.[238] The design of managed competition is singlemindedly structured to create price competition among health care providers.[239]

Quality competition would indirectly arise in managed competition under the guise of efficiency. Alliances and managed care companies, in measuring outcomes, would be searching for the highest return on their health care investment. Providers with poor outcomes would cause a patient to need more health care services, which in turn would increase the price paid to care for the patient. The increased price would be noticed, and the services of the provider necessarily avoided by alliances and managed care companies. As a result, although alliances and managed care companies might not specifically search for quality, their search for the best return on their health care dollar will result in a preference for quality care.

3. Counteracting the Physician's Effect on Supply

The physicians' effect on supply, a concern of CON proponents, is overcome in a managed competition state by the HMO's effect on supply.[240] HMOs counteract a physician's ability to order excessive or unnecessary medical treatment by implementing utilization review programs.[241] Utilization review requires a physician to seek prior approval from the HMO before commencing with non-emergency medical procedures, and allows a managed care company to "look back at the care rendered to check whether [the care] was appropriate."[242]

Managed competition also thwarts the physician's effect on supply via capitation. Capitation is "[a] method of reimbursement, typically used by health-maintenance organizations, in which health-care

providers receive a fixed payment for every patient regardless of how much care individual patients need."[243] Capitation provides financial disincentives for doctors and providers who would order too many tests or too many patient visits.[244] Therefore, even a doctor with a light schedule will not have the incentive to see his patients any more than medically necessary.[245]

Typically, utilization review and capitation are methods used by HMOs, but under managed competition, governmental health boards would have the authority to design and mandate the use of integrated delivery systems which incorporate utilization review and capitation.[246] Should a given delivery system prove too costly, the health board can redesign it to include utilization review and capitation. In short, managed competition arms the health care consumer with a powerful weapon to battle effectively a spendthrift physician.

4. Elimination of the "Roemer Effect" on Demand

A final component of the perceived need to control the unnecessary duplication of health resources results from the "Roemer Effect" view that the demand for medical services can be adversely controlled and manipulated by health care providers.[247] Under managed competition, health care providers are thwarted from generating demand for their services. Managed care companies require pre-admission certification before a physician can admit a patient to the hospital.[248] Thus, only medically necessary admissions will be made, as the hospital's incentive to fill beds is counterbalanced by the managed care company's desire to avoid paying for a filled bed.[249]

In addition, under a managed competition system with a balanced health care budget requirement, such as that suggested by the Jackson Hole Group, alliances would strongly resist any unnecessary cost.[250] If resistance is futile, governmental health boards can mandate the redesign of delivery systems to incorporate sufficient deterrents to the Roemer Effect.[251]

In sum, managed competition creates a health care marketplace where adequate incentives exist to prevent the unnecessary duplication of health care costs. Purchase costs are internalized. Competition is based on price and quality. Physicians have little or no effect on supply and the "Roemer Effect" no longer affects demand.

C. Achieving Equal Access to Quality Health Care at a Reasonable Cost

Managed competition also creates a health care marketplace with an excellent chance of achieving equal access to quality health care at a reasonable cost. CON laws state an intent to achieve equal access at reasonable cost, but rarely include any action to implement that intent.[252] The managed competition health care model includes a clear action plan to achieve equal access at reasonable cost. Via governmental alliances, the disadvantaged can share in the purchasing power of government agencies.[253] These alliances have the single goal of making private insurance more accessible and affordable to disadvantaged individuals through collective bargaining power.[254] No hard evidence has yet proven that alliances will succeed, but even an unproven plan such as that offered by managed competition is preferable to the failed plan offered by CON.

V. A Case Study: How Florida's Certificate of Need Laws Operate and Conflict with Managed Competition Health Care Reform

Florida provides a prime example of the conflict between CON and managed competition.[255] In order to illustrate best the conflict, the following discussion presents Florida's CON laws and Florida's interpretation of managed competition.[256] The discussion then identifies the Legislature's

acknowledgement of the conflict between CON and managed competition.[257]

The origin of CON in Florida parallels other states' similar laws, originating from local community efforts to allocate philanthropic and federal funding.[258] Florida's first CON laws were part of the Health Facilities and Health Services Planning Act, passed just one year before the effective date of the Congressional mandate.[259]

A. How the Certificate of Need Program Operates in Florida Today: The Statutes and Rules

Florida's current CON statutes are known as the "Health Facility and Services Development Act."[260] The statutes are supplemented by agency-promulgated administrative codes.[261] The structure of the statutes and rules still shows the influence of the 1974 National Health Act.[262]

Under Florida law, anyone operating a hospital, nursing home, or intermediate care facility without first obtaining a CON is guilty of a second degree misdemeanor.[263] Additionally, anyone operating without a necessary CON can be fined up to $5,000 for every day the facility operates without the certificate.[264] Thus, Florida health care facilities are very aware of CON laws.

1. Determining Whether a Given Project Requires a Certificate of Need

Before breaking ground for construction, offering a new service, or purchasing medical equipment, a Florida health care facility should first determine whether the new project or purchase will require a CON.[265] Certain projects are exempted from CON review.[266] To determine whether a project or purchase is exempt, the safest and most cost-effective method is to file a request for exemption[267] with Florida's Agency for Health Care Administration (AHCA or Agency).[268]

2. Securing a Certificate of Need

Projects requiring a CON in Florida include, but are not limited to, new construction,[269] capital expenditures beyond a specified limit,[270] conversion of one type of health care facility to another,[271] changes in licensed bed capacity,[272] establishment of a home health agency or hospice,[273] establishment of inpatient institutional health services,[274] acquisition of a facility,[275] acquisition of major medical equipment,[276] exceeding the approved budget when constructing a facility,[277] establishment of tertiary health services,[278] and a change in the number of psychiatric or rehabilitation beds.[279] In order to obtain a CON, the applicant must follow the administrative rules promulgated by the Agency and involving local health councils.[280]

a. Step One: Letter of Intent

The first step to securing a necessary CON is to file a letter of intent with the Agency and with the local health council for the area in which the project will be located.[281] "The letter of intent process has become the major hurdle for an applicant to overcome . . . ."[282] The letter of intent must include the legal name, mailing address, and telephone number of the applicant,[283] a specific description of the project,[284] proposed capital expenditures,[285] the number of beds sought,[286] services to be provided,[287] type of equipment and method of acquiring that equipment,[288] subdistrict location to be served,[289] and a certified copy of a resolution of the applicant's Board of Directors authorizing the project.[290] No CON can be issued to an applicant that does not properly file an adequate letter of intent.[291] Even if the letter of intent appears proper and passes initial scrutiny, a flawed letter of intent can cause a winning applicant to lose his CON if challenged in an administrative proceeding.

b. Step Two: Filing of the CON Application

After properly filing a letter of intent, a CON application may be submitted. The CON application must be filed with the Agency and the local health council by the batching cycle deadline and must be submitted in the proper form.[292] The required contents for the CON application are enumerated by statute and rule.[293] The practitioner should review successful CON applications before drafting his own.[294] The wise practitioner also includes "letters, testimonials, resolutions, and similar documents to bolster the presentation of [his] case."[295]

If the Agency determines that the proposed project involves issues of great public importance, then the Agency may hold a public hearing.[296] Otherwise, the Agency has sixty days[297] to issue a State Agency Action Report (SAAR) and Notice of Intent which will either grant the CON in its entirety, grant a CON for a specific portion of the project, or deny the CON.[298] The Agency must publish its proposed decision in the Florida Administrative Weekly within fourteen days after issuing the SAAR and Notice of Intent.[299] Any "substantially affected person,"[300] within twenty-one days after publication, may request an administrative hearing by filing a petition with the Agency[301] and serving a copy of the petition on the successful applicant.[302] Any applicant denied a certificate of need in the same batching cycle has a right to an administrative hearing if requested within twenty-one days of the Agency's publication of its decision.[303] Hearings are held in Tallahassee, Florida unless a change in venue will facilitate the proceedings.[304]

B. Florida's Managed Competition Laws

As the preceeding discussion illustrates, Florida's CON laws are typical of those found in most states. Florida is atypical, however, in its commitment to adopt a managed competition health care strategy. Today in Florida, managed competition is slowly becoming a reality. In 1993, Florida's legislature responded to the plight of 2.5 million uninsured Floridians[305] by making Florida the first state to adopt a managed competition health care strategy.[306] The enacting law is dubbed the "Health Care and Insurance Reform Act of 1993."[307] In order to understand how certificate of need laws will conflict with Florida's managed competition plan, a summary of Florida's managed competition system is presented.[308]

1. Managed Competition As Implemented in Florida

> It is the intent of the [Florida] Legislature that a structured health care competition model, known as "managed competition," be implemented . . . . The managed competition model will promote the pooling of purchaser and consumer buying power; ensure informed cost-conscious consumer choice of managed care plans; reward providers for high-quality, economical care; increase access to care for uninsured persons; and control the rate of health inflation in health care costs.[309]

This preamble to Florida's Health Care and Insurance Reform Act of 1993 is the guiding intent for Florida's Agency for Health Care Administration, which is charged with implementing the rules and regulations to create a managed competition health care marketplace in Florida.[310] The Agency calls Florida's new health care strategy "a voluntary, market-based managed competition model."[311]

a. Florida's Health Boards and Alliances

In the Florida model, Accountable Health Partnerships, or AHPs,[312] will perform the role of governmental alliances,[313] and Community Health Care Purchasing Alliances, or CHPAs,[314] will

perform the role of governmental health boards.[315] An AHP is defined as "an organization that integrates health care providers and facilities and assumes risk, in order to provide health care services."[316] A CHPA is defined as a "state-chartered, nonprofit organization that provides member-purchasing services and detailed information to its members on comparative prices, usage, outcomes, quality, and enrollee satisfaction with [AHPs]."[317]

A CHPA, therefore, is a group purchasing mechanism.[318] An AHP is the entity that actually delivers health services to CHPA members.[319] AHPs may be created by health care providers, HMOs, or health insurers, so long as licensing and competency requirements are met.[320] CHPA membership is voluntary,[321] but all CHPA members must purchase their health care services from an approved AHP.

Florida's AHPs are required to use managed care procedures for containing costs, including utilization management,[322] HEDIS-style monitoring,[323] and monitoring of access,[324] grievances,[325] and outcomes.[326] AHPs must contract in advance with providers in order to obtain health care services at the lowest price, because only the AHP with the lowest, adequate response to a CHPAs request for proposal will be awarded the right to provide health care to individuals residing in the AHP's geographical area.[327]

b. Florida's Managed Competition Private Health Plans

Various managed care companies will perform the role of private health plans,[328] including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Exclusive Provider Organizations (EPOs), and point-of-service plans.[329] Florida will also offer "pure indemnity plans," which are the equivalent of third party fee-for-service insurance plans.[330]

c. Rough Beginnings: The Difficulty in Implementation, the Likelihood of Failure, and the Questionable Constitutionality of Florida's Managed Competition

Implementing managed competition in Florida is proving to be a slow process. During the 1994 legislative session, only one managed care bill became law.[331] Likewise, the 1995 regular session passed only one managed care bill, and the passage of additional managed care bills in a special session appears doubtful.

Some predict that Florida's managed competition, as currently being implemented, is doomed to failure.[332] The characteristic cited by those who predict failure is that Florida will not require small employers to purchase coverage through the CHPAs and will not require that employers or individuals purchase health insurance.[333] Due to this characteristic, Florida's CHPAs "cannot bear any risk or make adjustments to compensate for risk between plans."[334]

The Legislature, as well as finding difficulty in passing managed competition laws, may also encounter difficulty in drafting managed competition laws that withstand constitutional attack. In *Albertson's, Inc. v. Department of Professional Regulation*,[335] the District Court of Appeal affirmed the trial court's determination that part of the Florida Health Care and Insurance Reform Act of 1993 violates the Commerce Clause of the United States Constitution.[336] The unconstitutional provision[337] of the Act involved the legislation's attempt to allow Florida small business pharmacies, or "independent" pharmacies, to sell prescriptions to CHPA members even though the "independent" pharmacies were not affiliated with an approved AHP.[338] This "independent" exception was intended to benefit only the smallest of small businesses, and therefore did not apply to businesses owning more than twelve Florida pharmacies or owning any non-Florida pharmacies.[339] The exclusion of non-Florida pharmacies was found on its face to place an impermissible burden on interstate commerce, but the exclusion of

businesses owning more than twelve Florida pharmacies was facially upheld.[340]

Albertson's illustrates the difficulty of implementing managed competition on a state rather than national level. Managed competition attempts to lower health care costs by affecting who enters the marketplace and on what terms.[341] State managed competition laws will therefore inevitably have a substantial effect on interstate commerce. *Albertson's* is an elementary case foreshadowing more difficult cases in which state managed competition laws will be alleged to be unconstitutional as applied to a given plaintiff. In those future cases, a state's managed competition law will survive only if the law is narrowly drawn to cause only an incidental effect on interstate commerce.[342] The theory of managed competition, however, is not narrowly drawn. The more areas of commerce that managed competition can affect, the more effective managed competition becomes. *Albertson's* suggests that, although state legislatures can proceed far down the path toward managed competition, federal legislation may ultimately be needed in order to enact completely the managed competition system.

2. Florida's Certificate of Need Statutes Cannot Co-Exist with Managed Competition

The Florida Legislature faces delays and problems in implementing managed competition, but has nevertheless succeeded in implementing more managed competition reform than any other state legislature.[343] However, gravely looming on Florida's horizon is the problem of managed competition's conflict with Florida's CON laws. As Florida's Agency for Health Care Administration grudgingly acknowledges, the goals of managed competition in Florida are indistinguishable from the goals of CON:

> It was not until 1993, however, when the Legislature passed the Health Care and Insurance Reform Act that a major issue about the continuation of the CON program emerged. The managed competition model adopted by the 1993 Legislature is intended to accomplish many of the same objectives as the CON program.[344]

The Agency is correct in stating that Florida's managed competition model is intended to accomplish the same goals as CON. For example, managed competition is designed to "control the rate of inflation in health care costs,"[345] while CON is designed to "[e]valuate the availability of more cost-effective service alternatives" and "[p]revent unnecessary hospital capital expenditures."[346] Managed competition will "reward providers for high-quality, economical care,"[347] while CON will "[s]elect providers with a proven quality of care record."[348] Managed competition should "increase access to care for uninsured persons,"[349] while CON should "[p]rovide access by predicating CON approval on serving indigent and other underserved persons."[350] Florida's managed competition laws, therefore, will be designed to achieve the same goals as Florida's CON laws. The only difference will be in the means to the end,[351] and, as history has proven, the means chosen by CON laws are ineffective.[352]

a. Florida has No Need for Certificates of Need Under Managed Competition

The Florida Legislature must do more than merely note the Agency's acknowledgment that CON and managed competition have the same goals. The Legislature must recognize that CON is unnecessary under managed competition, and that the reasons and rationale justifying CON no longer exist.[353]

CHPAs create market incentives to restrain health care costs adequately by acting as powerful purchasers who have the market clout to demand lower prices. CHPAs can achieve this effect by choosing AHPs via requests for proposals.[354] The request for proposal is a formal method for soliciting bids from AHPs which contain detailed financial and service statements and allow CHPAs to evaluate AHPs on equal terms.[355] To win a bid, an AHP must cut costs at every possible level, while

a committee substitute[371] which only "removes certain health care projects from the certificate-of-need review requirements . . . ."[372] Even this bill was replaced by a second committee substitute[373] that only "modifies certain licensure requirements applicable to hospitals and ambulatory surgical centers . . . ."[374] The final bill that passed the Committee made no mention of repealing CON.[375] On May 11, 1995, the bill died in the Ways and Means Committee.

The Senator or Representative who next proposes to repeal CON will evidently face an uphill battle. However, as CON begins to affect managed competition reforms adversely, the uphill battle may eventually be won.

VI. CONCLUSION

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. Nevertheless, CON persists in thirty-eight states, including Florida. These states are finding that the reasons and rationale justifying CON no longer exist under managed competition health care strategy. Managed competition creates market incentives to restrain health care costs adequately by promoting a managerial role for managed care companies. Managed competition creates adequate incentives to prevent the unnecessary duplication of health care costs because purchase costs are internalized, competition is based on price and quality, physicians have little or no effect on supply, and the "Roemer Effect" no longer affects demand. Managed competition even fosters equal access to health care at a reasonable cost by providing governmental alliances with the power to negotiate on behalf of the disadvantaged.

CON has historically failed to control health care costs, yet the new managed competition model is likely to succeed. However, the perpetuation of CON threatens the success of managed competition. States should therefore repeal their outdated CON laws when implementing the managed competition health care strategy. Out with the old health care reforms; in with the new.

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[*] The author thanks Mr. Dubose Ausley, whose financial support helped make this research possible. This Comment is dedicated to Joan McGinley, Alice Reynolds, and John Reynolds, the best friends a son and nephew could have. Return to text.

[1] Clark C. Havighurst, *Contract Failure in the Market for Health Services*, 29 WAKE FOREST L. REV. 47, 47 (1994) [hereinafter Havighurst, *Contract Failure in Health Care*]. Return to text.

[2] Commentators identify a definite trend toward the adoption of the managed competition health care strategy:

> Managed competition is the theory underlying not only President Clinton's health care reform proposal, but also the leading alternative plans proposed by conservative Democrats and moderate Republicans. Additionally, managed competition is being pursued in many states and by many private employers, and has been advanced as the fundamental basis for health care reform by private interest groups as diverse as hospitals, doctors, labor unions, and businesses. Therefore, it is no longer necessary to speculate whether managed competition in some form will be adopted.

The Other Sides Argument:

Why CON laws should be upheld

Eliminating the Certificate of Need requirements would increase health care costs.

Rebuttal: Since the 1980's when states were set free from the federal requirements to have CON laws, numerous studies have examined the change in health care costs as states eliminated their laws. *If CON laws were "working" as advertised, then one would expect to see a rise in health care costs in states where laws were eliminated. But in fact this is not the case. One of the most widely referenced studies was written by Duke University Professors Christopher Conover and Frank Sloan and published in the *Journal of Health Politics, Policy, and Law*. They found that output restrictions which resulted from CON laws led to higher not lower costs, and higher profits for existing providers (hospitals). The authors point out that CON laws resulted in higher costs per day and per admission in states with CON regulations, along with higher hospital profits. So, in states where CON laws remained, patients were charged more money, more often than in states that repealed the law. Simply put, the result of repealing CON regulations is lower health care costs for the people of that state. It's just as wrong-headed to think that limiting the supply of health care facilities can reduce health care costs, as it would be to think that oil prices could be brought down with further reductions in oil production.

If Alaska's CON regulations are repealed, the hospitals will no longer be able to provide care to the indigent or poor.

Rebuttal: The argument here is that entry restrictions, and the higher prices and profits that go along with them, are necessary to induce providers to provide free indigent care. So let me get this straight…the cost of health care and the profits to hospitals are purposely kept high by granting monopoly privileges. It is then expected that these excess profits will be used to provide free health care to the indigent. So health care customers are forced to pay a premium created by CON laws and the proceeds from this premium are used to pay for indigent care. This directly contradicts any "cost-savings" argument made by supporters of CON. If patients are paying a higher price in order encourage indigent care, then CON regulations are driving prices up, not down. Additionally, the State's use of non-medical criteria in deciding whether to approve a Certificate of Need (like an applicant's record of providing charity care) is evidence that the process has become arcane and politicized. Finally, the "free" indigent care the hospitals are providing is actually being paid for by the government in the form of huge subsides granted to them for such care. If the care is paid for by the state, why are we really charging patients a premium?

Repealing the Certificate of Need laws in Alaska would lead to the development of ASC's which are cited as a major cause of Hospital closures across the country.

Rebuttal: From 1987 – 1994, a period that saw more than a doubling of the number of ASC's in this country, the number of Hospital closures declined. Numerous other factors however, have been cited for hospital closures including:

a) Hospital mergers and acquisitions leading to large scale market consolidation during the 1990's
b) Failure to adjust to managed care and large reductions in average length of stay
c) The excess bed capacity of hospitals during the shift from inpatient to outpatient care.

State Commission on the Efficacy of the Certificate of Need Program and its Effect on Cost, Quality, and Access in Georgia; 08/08/2005

Free Market competition can't work as a means of cost-control in the health care industry.

Rebuttal: The idea that in the area of health care services free market competition can't work as a means of cost control is not grounded in either economic theory or empirical evidence. Competition is widely considered by economists as *the* most effective tool for driving down costs, something Alaska desperately needs. In areas where competition is allowed to flourish, the customer is well served with plenty of options and competitive pricing. Further, it is competition that provides the incentives to discover new technologies and new efficiencies for delivering those technologies to patients. Lastly, believing that CON laws and the bureaucrats that administer them can do a better job at containing costs than the competitive market process is not only wishful thinking, it's the economic equivalent to believing the earth is flat. Everyday experience shows that when the market is free to operate under minimal government oversight, the result is abundant, quality service and low price.

Repealing CON regulations would lead to duplication of facilities and services.

Rebuttal: Facility duplication is at the heart of competition. Indeed, the definition of a monopoly market is one where there is no duplication. And this is why customers in monopoly markets lose; they are denied the option of turning to others who are providing "duplicated" services when monopoly providers act like monopolists.

John Barnes, Policy Analyst
jbarnes@washingtonpolicy.org

Concerns regarding the fiscal note for Alaska's HB 287 (2006)

Scaling Down Certificate of Need Requirements

- Too little explanation of the fiscal note estimates. How *exactly* did they arrive at these numbers? This is especially important if the crux of the argument against scaling down CON laws is the fiscal impact on the state.

- The department predicts $2.7 million in expenditures for Cardiac Hospitals starting in FY2010, but admits there have not been any specific inquiries for such facilities.

- The department admits uncertainty with the numbers for various reasons, but insists their estimates are "conservative." This does not make sense. If this is true uncertainty, then their estimates could be high as well.

- In general, the department makes estimates and projections for several years down the road. You cannot assume this to be accurate. Financial estimates for that far out are laden with problems because of shifting variables and unpredictable circumstances. The general unreliability of state projections and projection methodologies is a large reason why CON laws do not help control health care costs. You cannot centrally-plan for the present or the near future, much less 6 or 7 years down the road.

- The department makes a $2.7 million projection for Orthopedic Hospitals without providing demonstration of interest. They state simply that "it is only a matter of time before they move to Alaska," and make a projection for FY2012. Fiscal notes ought not be based on the *supposed* inevitability of anything, and a projection for 6 or 7 years down the road is informed speculation at best due to shifting economic and demographic factors.

- In general, the calculation methodology (that which can be seen, at any rate) is suspect. The department is basing its estimation of facilities that would be built in a post-CON era on letters of intent and applications received in the past. But letters and applications are filed with the understanding that CON may not be granted. They are filed in an attempt to enter a market where providers are insulated from competition, where success is much more assured. When there is no CON barrier, providers have to be more careful in deciding to enter the market, and some who filed letters and applications would not actually proceed with projects because the likelihood for success changed. **You cannot assume that the number of letters and applications reflect the likely number of new facilities**.

- The fiscal note is based on the *assumption* that a massive supply surge will follow a CON downscaling. That is not necessarily true. A 1998 empirical study published in *Journal of Health Politics, Policy, and Law* examined health spending between the late 1970s and 1993

and found that in states that repealed CON laws, there was no surge in health spending.[1] This evidence contradicts the fiscal note's projections. [If this surge does occur, it will reflect the fact that the supply was abnormally depressed due to CON in the first place. In the long run Alaska will experience a leveling off of supply that reflects true demand.]

- A 2003 study by three leading authorities in the field of health policy found that aggregate state-level data from 1981 through 1998 shows states that repealed their CON and moratorium laws had no significant growth in either nursing home or long-term care Medicaid expenditures.[2] This evidence contradicts the fiscal note's projections, and *even if these facilities are not included in the bill, this evidence calls into question the department's methodology for fiscal impact and its assumptions in general.*

- Fiscal note numbers do not reflect the potential for cost reduction in the aftermath of CON downscaling. CON laws curtail services and facilities, often forcing patients into more expensive substitutes, thus increasing costs for patients or third-party payers. EXAMPLE: if nursing home beds are not available, the discharge of patients from more expensive hospital beds may be delayed or patients may be forced to use a more expensive nursing home.

- Fiscal note numbers do not take into account the potential for savings through reduced administrative costs, less personnel time, etc. If less time and resources are being spent running CON, that's money saved. This is true for business as well. Many businesses have entire departments devoted to just the CON process.

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[1] Christopher Conover and Frank Sloan. "Does removing certificate-of-need regulations lead to a surge in health care spending?" *Journal of Health Politics, Policy, and Law*, Vol. 23, Issue 3.

[2] David C. Grabowski, Robert L. Ohsfeldt, and Michael A. Morrisey. "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures," *Inquiry* 40 (Summer 2003): 146-157.

National CON Perspective and Experience

Impact Report of Deregulation

Thomas R. Piper

Principal, MacQuest Consulting

a presentation to the

Alaska House Health, Education, and Social Services Committee

at the March 28, 2006, hearing related to House Bill 287

The CON Matrix of

2005 Relative Scope and Review Thresholds: CON Regulated Services by State

Minimal CON Regulation

Ohio General Assembly **repealed** CON in 1995

- 20-year duration
- All facilities
- Services
- Beds
- Capital
- Equipment
- (except long term care)

*authored by **Gretchen McBeath**, JD, Bricker & Eckler Law*

Phase Out 1995-1998

- Solid organ transplantation — March 1, 1998
- Bone marrow programs — March 1, 1998
- Cardiac catheterization — March 1, 1998
- Open heart surgery — March 1, 1998
- New hospitals — May 1, 1997
- Freestanding dialysis centers — May 1, 1996 (MSA), May 1, 1997 (rural)
- Hospital-based dialysis — May 1, 1995
- Ambulatory surgery facilities — May 1, 1996 (MSA); May 1, 1997 (rural)
- Freestanding/mobile MRI — May 1, 1996 (MSA), May 1, 1997 (rural)
- Hospital-based MRI — May 1, 1995
- Capital improvements — May 1, 1995
- Low risk OB/newborn — May 1, 1995
- High risk OB/newborn — March 1, 1998
- Hospital beds — May 1, 1995
- Linear accelerators — March 1, 1998
- Gamma knives — March 1, 1998
- Other equipment — May 1, 1995

No Hospital Licensure- Quality Review instead

- cardiac catheterization
- open heart surgery
- obstetrics and newborn
- radiation therapy
- pediatric ICU units
- solid organ transplantation services
- bone marrow and
- stem cell transplant programs
- psychiatric and obstetric/newborn units (exception)

Free-Standing Services are Licensed

- Ambulatory surgery facilities
- Diagnostic imaging
- Dialysis
- Others

Ohio Hospitals Closed since Deregulation

	Before Deregulation		December 2000	
	# Hospitals	Beds	# Hospitals	Beds
Urban hospitals	62	25,091	56	20,994
Community hospitals	76	16,019	71	15,420
Rural hospitals	52	4,240	46	3,929
Psych/alcohol/rehab	24	1,239	18	1,035
Hospitals within a hosp	0	0	15	528
Total	**214**	**46,589**	**206**	**41,906**

Detail of Hospitals Opened since Deregulation

Type of Hospital	Number*	Number of Beds
Urban/cardiac**	2	71
Mid-size community	1	206
Rural	1	24
Hospitals within a hospital	15	528
Total	**19**	**829**

**two more in planning*

***two inner-city moved to suburbs*

Hospital Bed Decline since Deregulation

Type of bed	Before deregulation	December 2000
Special care	3,284	3,097
Med/surg	31,331	27,256
Obstetrics	2,715	2,462
Pediatric	2,808	2,649
Psychiatric	3,610	3,266
Rehab	1,618	1,790
Alcohol	1,530	928
Burn	111	103
Total	**47,007**	**41,551**

Cardiac Cath Increase since Deregulation

	Before Dereg	After Dereg
Number of Ohio hospitals*	190	173
Hospitals with cardiac cath	86 (42%)	94 (54%)
Hospitals with open heart surgery	38 (20%)	50 (29%)

**Ohio law allows these services in hospitals only*

Diagnostic Imaging Increase since Deregulation

	1995	1999
Non-hospital-based Mobile or free-standing MRIs	23	126*
Hospital with in-house MRIs	35	almost all

Notices of Intent filed for 65 more since then

Radiation Therapy Increase since Deregulation

	1998	1999
Non-hospital-based free-standing radiation therapy	10	28*
Hospitals with radiation therapy	?	2 added

Notices of Intent filed for 6 more since then

Ambulatory Surgery Facility Increase since Deregulation

	1995	2001
Ambulatory surgery facilities	31	186*

(many new ASFs are physician owned and operated**)

*about 30 are eye-surgery-only facilities

**hidden effect in small communities: joint-ventures and hosp/phys adversity

Outpatient Dialysis Increase since Deregulation

	1995	2001
Outpatient dialysis stations	1,053*	2,100+

(1) additions to existing dialysis programs in hospitals and freestanding facilities;

(2) new hospital-based dialysis programs; and

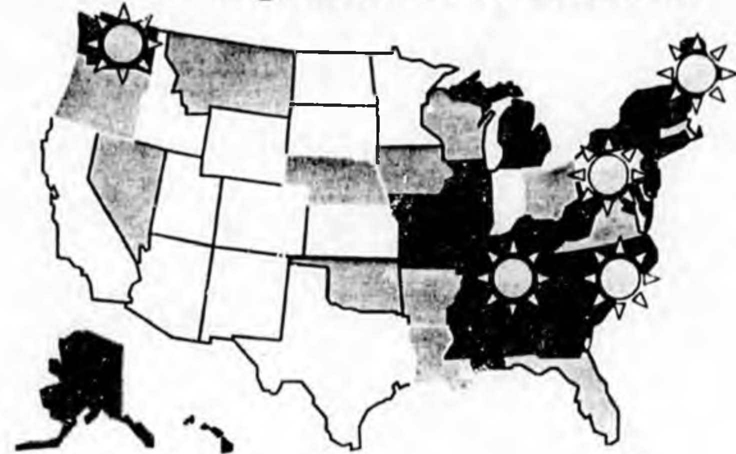
(3) new freestanding facilities

*original projections that 40 more needed

Main Characteristics of Deregulation in Ohio

- a significant loss of inner city hospitals
- a substantial increase in ambulatory surgery facilities and other freestanding facilities
- hospitals have become more competitive.

No useable statistics on capital expenditures have been available since deregulation.



Balance Regulation and Competition: Protect Community Interests

- Promote the development of community-oriented health services and facility plans
- Provide pricing and quality information to consumers so that they have an educated choice
- Provide a public forum to ensure that the community has a voice in health care

Status Report on Ohio After Deregulation from Certificate of Need

Authored by Gretchen McBeath, Bricker & Eckler LLP
Presented by Thomas R. Piper, MacQuest Consulting
Alaska House Health, Education, and Social Services Committee
at the March 28, 2006 hearing related to House Bill 287

In 1995 the Ohio General Assembly repealed Ohio's twenty year certificate of need program for all facilities, services, beds, capital, and equipment, except for long term care facilities which remain indefinitely subject to certificate of need review. This article examines the situation in Ohio after deregulation and the information is current through September 2001 (no info tracked thereafter).

Deregulation Schedule

Ohio phased out its certificate of need program during a period starting in May 1995 and concluding March 1, 1998. Currently, everything in Ohio is deregulated and no longer subject to CON except for long-term care services. All activities associated with the long-term care industry, both freestanding and hospital-based, continue under certificate of need indefinitely. The Ohio phase-out took place according to the following schedule:

Solid organ transplantation	March 1, 1998
Bone marrow programs	March 1, 1998
Cardiac catheterization	March 1, 1998
Open heart surgery	March 1, 1998
New hospitals	May 1, 1997
Freestanding dialysis centers	May 1, 1996 (MSA); May 1, 1997 (rural)
Hospital-based dialysis	May 1, 1995
Ambulatory surgery facilities	May 1, 1996 (MSA); May 1, 1997 (rural)
Freestanding/mobile MRI	May 1, 1996 (MSA); May 1, 1997 (rural)
Hospital-based MRI	May 1, 1995
Capital improvements	May 1, 1995
Low risk OB/newborn	May 1, 1995
High risk OB/newborn	March 1, 1998
Hospital beds	May 1, 1995
Linear accelerators	March 1, 1998
Gamma knives	March 1, 1998
Other equipment	May 1, 1995

Ohio does not have a hospital licensure program but individual services are subject to quality review, similar to a licensure program. These services include

cardiac catheterization, open heart surgery, obstetrics and newborn, radiation therapy, pediatric ICU units, solid organ transplantation services, bone marrow and stem cell transplant programs. In addition, psychiatric units and obstetric/newborn units are subject to licensure. Most freestanding facilities such as ASFs, diagnostic imaging, dialysis are licensed. These licensure and quality review programs have not been a barrier to entrants seeking to establish new facilities and services.

Hospitals

New hospitals in Ohio have been deregulated since May, 1997. Although there have been some new hospitals built in Ohio, and a few more on the drawing board, the bigger story is the number of hospitals that have closed since deregulation.

	Before Deregulation		December 2000	
	# Hospitals	Beds	# Hospitals	Beds
Urban hospitals	62	25.091	56	20,994
Community hospitals	76	16,019	71	15,420
Rural hospitals	52	4,240	46	3,929
Psych/alcohol/rehab hospitals	24	1,239	18	1,035
Hospitals within a hospital	0	0	15	528
Total	214	46,589	206	41,906

The closure situation has been most dramatic in the inner cities where 9 long-standing large hospitals have closed. The breakdown of the closures and openings is as follows:

Hospitals Closed Since Deregulation

Type of Hospital	Number	Number of Beds
Urban/general	11	3,602
Mid-size community	6	1,001
Rural	4	265
Psychiatric/alcohol	6	538
Total	27	5,406

Hospitals Opened Since Deregulation

Type of Hospital	Number	Number of Beds
Urban/cardiac	2	71
Mid-size community	1	206
Rural	1	24
Hospitals within a hospital	15	528
Total	19	829

There are at least two additional hospitals either planned or actually under construction. One is a full-service hospital in Toledo and the other is a cardiac

hospital in Columbus. The Toledo hospital will have 70 beds and plans to open in November 2001.

It is significant that at least two of the large inner city hospitals that have closed were closed at a result of movement to the suburbs. In these cases, the inner city hospital acquired a small suburban hospital, expanded it, transferred the tertiary services from the inner city facility and then closed the inner city facility. This is obviously an attempt to capture more of the affluent suburban market that is currently not coming to the old inner city hospitals.

Hospital Beds

Ohio has experienced a decline in the number of hospital beds since the 1995 deregulation from certificate of need. As shown below, total hospital beds at the end of 2000 had decreased by 5,456. Most of this decrease is a direct result of the closures of the large urban hospitals discussed above.

Type of bed	Before deregulation	December 2000
Special care	3,284	3,097
Med/surg	31,331	27,256
Obstetrics	2,715	2,462
Pediatric	2,808	2,649
Psychiatric	3,610	3,266
Rehab	1,618	1,790
Alcohol	1,530	928
Burn	111	103
Total	47,007	41,551

***NOTE: The total bed numbers shown at the end of December 2000 here and the closures and openings of beds (above) do not precisely match due to the different time periods from which the two sets of numbers were derived. Also, bed numbers in both listings exclude nursery beds and SNF beds.**

Cardiac Services

Cardiac catheterization and open heart surgery were deregulated effective March 1, 1998. Ohio law currently prohibits cath labs and open heart surgery unless performed in a hospital. As of September 2001, the following statistics apply to cardiac services.

	Before deregulation	After deregulation
Number of Ohio hospitals*	190	173
Hospitals with cardiac cath	86 (42%)	94 (54%)
Hospitals with open heart surgery	38 (20%)	50 (29%)

***Includes only hospitals with medical/surgical capabilities and excludes psychiatric and other specialty hospitals**

Imaging

MRI's located in an existing hospital were deregulated as of May, 1995. Freestanding diagnostic imaging centers (a center which includes either an MRI or a CT scanner or both) were deregulated in MSA areas as of May 1, 1996 and in rural areas as of May 1, 1997. Immediately before deregulation, the Department of Health recognized 23 non-hospital-based mobile or freestanding MRI's in Ohio. As of July 1999, the Department listed 126 non-hospital-based mobile or freestanding MRI's. Since July 1999, another 65 notices of intent have been filed for additional MRI's.

Prior to deregulation, there were 35 hospitals that maintained in-hospital MRI's. Since deregulation, virtually every Ohio hospital of any size now has an in-house MRI.

Radiation Therapy

Freestanding radiation therapy facilities and radiation therapy programs in hospitals were deregulated in March of 1998. Prior to deregulation, there were approximately 10 freestanding (non-hospital based) radiation therapy facilities in Ohio. The Department of Health in July 1999 listed 28 such facilities and an additional 6 notice of intent for freestanding radiation therapy facilities have been filed since July 1999. It is difficult to know how many hospitals maintained radiation therapy services prior to deregulation, but only two hospitals have added the service since deregulation.

Ambulatory surgery facilities

This is an area of the high activity and the most local contention. ASF's have been deregulated in MSA areas since May 1, 1996 and in rural areas since May 1, 1997. An ASF is defined as any place where outpatient surgery is performed that is not in the same building where inpatient services are rendered. In 1995 prior to deregulation, the Department of Health listed 31 ambulatory surgery facilities in Ohio. As of the end of August 2001, there are 186 such facilities actually operating in Ohio or under construction. Of these 186, approximately 30 are eye surgery only facilities.

The vast majority of the new ASF's are physician owned and operated, although there are some chain operations as well. A somewhat hidden result of the certificate of need deregulation is the effect that physician owned ASF's or the threat of a physician owned ASF has had on the smaller communities. In several one and two hospital towns, the physicians have approached the hospital with their plan to build an ASF and propose to "back-off" from the project only if the hospital will use its capital to build the facility and let the physicians have a large share of the profits or if the hospital will give the physicians more management control of the hospital. This has had the effect of pitting hospitals against

physicians in several Ohio communities with some rather unpleasant results. Obviously, the hospital does not want to build an ASF for physicians' profit; on the other hand the hospital cannot afford to lose much outpatient surgical business and hope to survive. Some hospitals and physicians have agreed to joint venture ASFs; other hospitals are toughing it out and have threatened to revoke staff privileges against any physician that invests in a competitor operation with the hospital. This remains the most difficult problem with the deregulation of CON.

Outpatient dialysis

Outpatient dialysis stations located inside a hospital were deregulated in May 1995. Freestanding outpatient dialysis centers in MSA areas were deregulated in May 1996 and in rural areas in May 1997. Prior to deregulation, the Ohio Department of Health listed 1,053 existing certified outpatient dialysis stations and had determined there was a need for an additional 40 stations in the state. Since May 1995, over 1,000 new dialysis stations have been added in Ohio for a 100 percent increase in stations. These new stations represent: 1) additions to existing dialysis programs in hospitals and freestanding facilities; 2) new hospital-based dialysis programs; and 3) new freestanding facilities. New dialysis stations continue to be added on a regular basis in 2001 and there has not been a slow-down in expansion. Since it is doubtful that there has been a 100% increase in the number of dialysis patients to match these new stations, it is assumed that these dialysis facilities are operating fewer shifts than were the facilities before deregulation. Prior to deregulation, most dialysis facilities operated three, and in some cases, four shifts. It is likely that most of these have decreased to two shifts.

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Alaska State Medical Association

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March 28, 2006

Honorable Peggy Wilson
Alaska State House of Representatives
Chair, Health and Social Services Committee
State Capitol, Room 108
Juneau, AK 99801-1182

Re: HB 287 – Certificate of Need

Dear Representative Wilson:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

HB 287 would eliminate the Certificate of Need program in all boroughs with the exception of those with fewer than 25,000 people. ASMA supports HB 287 and urges you and all other members of the Health and Social Services Committee to support it as well.

For over twenty years ASMA has opposed certificate of need regulations on behalf of patients, access to care, quality of care, and the economic harm that results. The continuation of Alaska's Certificate of Need program is based on unproven assumptions of cost savings and quality outcomes.

The Department of Justice released a report in 2004, based on 27 days of DOJ/FTC Joint Hearings on Health Care and Competition Law and Policy, held from February through October 2003; an FTC sponsored workshop in September 2002; and independent research. The hearings gathered testimony and written comments from more than 300 participants, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from anti-trust and economics to health care quality and informed consent. Almost 6,000 pages of transcripts of the hearings and workshop and all written submissions are available on the DOJ's and FTC's website. The conclusion: reconsider whether certificate of need programs best serve their citizens'' health care needs. On balance, the DOJ and the FTC believe that such programs are not successful in containing health care costs, and they pose serious anticompetitive risks that usually outweigh their purported economic benefits. [1]

The American Medical Association policy certificate of need programs is also consistent. It's conclusion: our AMA believes that there is little evidence to suggest that certificate of need programs are effective in restraining health care costs or in limiting capital investment. In the absence of such evidence, the AMA reaffirms current policy opposing the extension of certificate of need to private physicians' offices. (CMS Rep. D, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00) [2]

[1] http://www.usdoj.gov/atr/public/press_releases/2004/204711.htm

[2] http://www.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/HnE/H-205.999HTM&s_t=certificate+of+need&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&&nth=1&&st_p=0&nth=1&

An article in the Anchorage Daily News on March 10, 2006, reported on a study done by University of Alaska researchers. It reported that last year's statewide health care spending was estimated to be $5.3 billion, which represents 1/6th of the value of all goods and services produced that year. This is better than three times the amount of health care expenditures in 1991 of $1.6 billion. We need to try a different approach.

In late August 2005, the Department of Health and Social services noticed proposed regulations that set the review standards for the Alaska Certificate of Need Program. ASMA provided written testimony opposing adoption of those proposed regulations. Those comments contained some of the same remarks provided in this testimony. You may wish to get the record of the testimony provided pertaining to those proposed regulations (including ASMA's). For example, as a urologist, I reviewed the Review Standards for lithotripsy and found the methodology has no basis in Alaska. Another was the Standard for computed tomography that favored the "sixteen slice" CT scanner that hospitals are installing to do cardiac imaging. Most individuals would be adequately served by single slice scanners at a fraction of the cost and at a fraction of the radiation dose.

My experience (as a health care consumer and patient) also evidences the problems with the Certificate of Need. My recent colonoscopy, done at a physicians owned entity, which would be precluded under the proposed regulations, was 40% of the cost had it been at one of the Anchorage area hospital endoscopy suites.

Those efforts to codify the Review Standards were well meaning but they are counterproductive. Consider that there is an entire universe of services and products that grow every day as new research and technologies come along. We are on the cusp of a revolution with the decoding of the human genome and the nanotechnology. There are currently 400 new drugs and treatments in clinical trails as well as millions undergoing basic research. At the same time, people are rediscovering a host of ancient practices such as herbal medicines, native treatments and acupuncture that were nearly lost in modern medicine's birth of penicillin.

No one can predict exactly how empowered consumers and advances in health care will behave. But that is the point. Free markets are effective because they are unpredictable and solve problems in ways that no one anticipates. (Note GOOGLE). And that is why a market-based system is essential.

ASMA urges you, as well as the other HESS Committee members, to support HB 287.

Sincerely,

By: Kevin Tomera, MD President
For: The Alaska State Medical Association

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March 30, 2006
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On the oil tax bills . . . .

Differences and consensus becoming clearer

The major issues yet to be resolved in oil tax legislation as well as areas of consensus are becoming clearer. The Senate Resources Committee finished its work on SB-305 March 29 and held it for a final look-over before sending it on to the Finance Committee. Meanwhile the House Finance Committee held hearings last week on the House Resources version of the bill, HB-488.

- Continued on page 8

House budget likely a non-budget

The House passed a $7.5 billion federal/state funded budget, with a 6 percent increase in draw on state general funds over the current year. This is likely a shell of a budget as will be the Senate budget. This year may require an old fashioned budget free conference to build a real budget, one that may include capital funding and so-called "discretionary funding."

Senate may strip public broadcast funding

A Senate Finance Committee subcommittee chaired by Sen. Fred Dyson, R-Chugiak, has voted to recommend to the full Finance Committee that funding for public broadcast be stripped from the budget. The subcommittee was to close out as we go to press.

- Continued on page 6

Health facility certificate of need debate opens

The House Health, Education, and Social Services last week opened hearings on repeal, or serious modification of the state controlled "Certificate of Need" process that now controls the construction of certain kinds of medical facilities. This is a debate that will not end this session, and is driven, in part, by a now-certified citizens initiative aimed at the 2008 ballot. The initiative is a full repeal, so legislators can either pass a modification bill sufficient to allow the initiative to be removed from the ballot, or let voters decide the issue.

- Continued on page 6

Alaska Legislative Digest & Alaska Economic Report
web page: www.akreports.com ISSN 3322-0023

Auto dealer fee disclosure proposed

In what appears to be a last-ditch effort to salvage their proposal to pay auto dealers for vehicle title and registration paperwork they now complete as a customer service, the sponsors of HB-344 have added a disclosure provision that at least one of them has adamantly opposed in a separate bill.

Sponsored by Reps. Vic Kohring and Jay Ramras, the bill would allow auto dealers who have been contracted as agents of the Division of Motor Vehicles to keep up to 7.5 percent of the state fees they collect. At a March 28 hearing before the House State Affairs Committee, Ramras proposed a revised draft including a requirement that dealer/agents disclose to car buyers the fees they charge for their services and state or municipal fees that are also imposed.

The revised bill was not adopted as the work document and Chair Rep. Paul Seaton (R-Homer) immediately put the measure aside without indicating plans for future hearing. A similar requirement for disclosure of dealers' so-called "doc fees" is a central element of HB-383, now awaiting a House floor vote.

ESC payments for worker training

Legislation that would divert a fraction of workers unemployment contributions to fund a six-year training program for pipeline and other construction jobs is expected to move out of the Senate Labor and Commerce Committee next week. SB-309 got unanimous support from employers, labor unions, individual workers and the state at a March 28 hearing. The bill was held for a March 30 hearing but pulled from that agenda by Chairman Con Bunde (R-Anch.).

The bill is intended to help fill the current construction worker shortage with state residents and prepare them for more than 8,600 jobs expected to be created when construction of a gas pipeline begins. It does not increase any taxes, but directs the diversion of .10 percent of employee contributions to a new holding account intended to be appropriated in grants to the Alaska Works Partnership, Inc. or successor nonprofits. The training will focus on construction jobs ranging from home building to highway and pipeline-related crafts. Grantees will be required to submit annual reports to the Department of Labor each Nov. 1.

Public broadcast funding - *continued*

- Continued from page 1

One interesting thing in the subcommittee action is that they did not reduce the total of funding, but reallocated funding to functions like public defenders and others. This suggests that the funds are still there to be replaced, although after using the item to do conference committee wrestling with the House.

Certificate of need - *continued*

Continued from page 1

We will be following the certificate-of-need (CON) debate in some detail, but it is also a complex issue needing print space. HB-287 is by Reps. Lynn, Coghill, Kohring, and Chenault, all Republicans. Reps. Lynn and Coghill are also sponsors of a voter initiative, eliminating all CON requirements. Certificate-of-need is a process requiring certain medical facilities over $1 million to obtain a CON from the Department of Health and Social Services. In recent years there have been increasing pressure from the physicians community to form (and own) outpatient specialty facilities, such as surgical and imaging centers. Hospitals see this draining their efficiency. The strategy of entrepreneurial physicians is to push the initiative, which could not come to the ballot prior to 2008, but offer opportunity for a modified version (HB-287), the latter which in present form already retains CON for psychiatric and nursing home facilities.

Rod L. Betit. President/CEO

Alaska State Hospital and Nursing Home Association

ASHNHA Testimony on HB 287 - Communities Exempt from Certificate of Need (CON)

As we read the provisions of HB 287, the bill would remove the requirement for CON review of all health care projects in the communities of Anchorage, Fairbanks, Homer, Juneau, Palmer/Wasilla, and Soldotna. ASHNHA's membership does not support this legislation for the following reasons:

- **CON is an important public health policy tool.**

Certificate of Need does not prohibit needed growth in Alaska's health care infrastructure, but rather is a process that assures additional services are needed in the area being proposed. Without a strong CON process, over-building of health care facilities would occur and new medical services may not be developed in the desired locations.

36 states plus the District of Columbia continue to require CON approval for one or more categories of health services. In addition, some states have discontinued CON and replaced it with an outright moratorium against new construction in certain areas further underscoring the critical need to restrain unneeded growth.

- **Recently finalized State regulations should be given an opportunity to work.**

In 2004 the Alaska Legislature made important changes to the CON law. State regulations implementing these changes have just recently been finalized after a lengthy review and public comment process. ASHNHA believes these carefully deliberated regulations should be given a chance to work.

Since reopening the CON process in 2005, the Department of Health & Social Services has approved a number of new health care projects and has allowed others to proceed without CON review. Well documented applications for additional service capacity are receiving favorable treatment under the new regulations to ultimately better serve Alaskans throughout the State.

- **Over investing in health care facilities, equipment and technology will place the financial stability of community hospitals at risk.**

When there are too many providers for a finite number of health care events, community hospitals are most at risk as revenues from their more profitable lines of business shrink. This leaves community hospitals struggling to finance the full array of services it must offer on a 24/7 basis to all residents regardless of ability to pay.

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- **Over building of medical infrastructure will further exacerbate the workforce shortage situation and drive up health care costs as providers compete to hire needed medical staff from this limited pool.** Alaska is already facing a critical shortage of physicians and nurses. This situation is not expected to improve in the short term. Many of the projects subject to CON review would require the most specialized professionals in radiology and surgery. If we do not control the growth in Alaska's medical infrastructure we will see staffing shortages in our hospitals and nursing homes beyond anything we have experienced to date.

ASHNHA believes the CON process is not overly burdensome to applicants who desire to enter the health care market or who desire to expand their services. Most CON applications are being approved. Those CON applications that have not been approved failed for one or more reasons. Either the project was not justified based on the criteria established by the Alaska Department of Health and Social Services to guide CON decisions, or the projects offered services in an area of the State that did not fit the need, or some other major problem existed with the application. Some of the denied projects can be resubmitted and approved once the problem areas are corrected. ASHNHA's members believe this is a rational and fair way to make medical care infrastructure decisions for all Alaskans.

ASHNHA's members respectfully urge you not to move this bill forward.

ASHNHA Represents the Following Alaska Health Care Facilities:

Alaska Regional Hospital, Alaska Native Medical Center, Alaska Pioneer Home System, Bartlett Regional Hospital, Bassett Army Community Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kanakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mary Conrad Center, Mat-Su Regional Hospital, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, USAF 3rd Medical Group- Elmendorf, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, Alaska Psychiatric Institute, North Star Behavioral Health System, Wildflower Court Nursing Home.

Status Report on Ohio After Deregulation from Certificate of Need

Authored by Gretchen McBeath, Bricker & Eckler LLP
Presented by Thomas R. Piper, MacQuest Consulting
Alaska House Health, Education, and Social Services Committee
at the March 28, 2006 hearing related to House Bill 287

In 1995 the Ohio General Assembly repealed Ohio's twenty year certificate of need program for all facilities, services, beds, capital, and equipment, except for long term care facilities which remain indefinitely subject to certificate of need review. This article examines the situation in Ohio after deregulation and the information is current through September 2001 (no info tracked thereafter).

Deregulation Schedule

Ohio phased out its certificate of need program during a period starting in May 1995 and concluding March 1, 1998. Currently, everything in Ohio is deregulated and no longer subject to CON except for long-term care services. All activities associated with the long-term care industry, both freestanding and hospital-based, continue under certificate of need indefinitely. The Ohio phase-out took place according to the following schedule:

Solid organ transplantation	March 1, 1998
Bone marrow programs	March 1, 1998
Cardiac catheterization	March 1, 1998
Open heart surgery	March 1, 1998
New hospitals	May 1, 1997
Freestanding dialysis centers	May 1, 1996 (MSA); May 1, 1997 (rural)
Hospital-based dialysis	May 1, 1995
Ambulatory surgery facilities	May 1, 1996 (MSA); May 1, 1997 (rural)
Freestanding/mobile MRI	May 1, 1996 (MSA); May 1, 1997 (rural)
Hospital-based MRI	May 1, 1995
Capital improvements	May 1, 1995
Low risk OB/newborn	May 1, 1995
High risk OB/newborn	March 1, 1998
Hospital beds	May 1, 1995
Linear accelerators	March 1, 1998
Gamma knives	March 1, 1998
Other equipment	May 1, 1995

Ohio does not have a hospital licensure program but individual services are subject to quality review, similar to a licensure program. These services include

cardiac catheterization, open heart surgery, obstetrics and newborn, radiation therapy, pediatric ICU units, solid organ transplantation services, bone marrow and stem cell transplant programs. In addition, psychiatric units and obstetric/newborn units are subject to licensure. Most freestanding facilities such as ASFs, diagnostic imaging, dialysis are licensed. These licensure and quality review programs have not been a barrier to entrants seeking to establish new facilities and services.

Hospitals

New hospitals in Ohio have been deregulated since May, 1997. Although there have been some new hospitals built in Ohio, and a few more on the drawing board, the bigger story is the number of hospitals that have closed since deregulation.

	Before Deregulation		**December 2000**	
	# Hospitals	**Beds**	**# Hospitals**	**Beds**
Urban hospitals	62	25.091	56	20,994
Community hospitals	76	16,019	71	15,420
Rural hospitals	52	4,240	46	3,929
Psych/alcohol/rehab hospitals	24	1,239	18	1,035
Hospitals within a hospital	0	0	15	528
Total	214	46,589	206	41,906

The closure situation has been most dramatic in the inner cities where 9 long-standing large hospitals have closed. The breakdown of the closures and openings is as follows:

Hospitals Closed Since Deregulation

Type of Hospital	**Number**	**Number of Beds**
Urban/general	11	3,602
Mid-size community	6	1,001
Rural	4	265
Psychiatric/alcohol	6	538
Total	27	5,406

Hospitals Opened Since Deregulation

Type of Hospital	**Number**	**Number of Beds**
Urban/cardiac	2	71
Mid-size community	1	206
Rural	1	24
Hospitals within a hospital	15	528
Total	19	829

There are at least two additional hospitals either planned or actually under construction. One is a full-service hospital in Toledo and the other is a cardiac

hospital in Columbus. The Toledo hospital will have 70 beds and plans to open in November 2001.

It is significant that at least two of the large inner city hospitals that have closed were closed at a result of movement to the suburbs. In these cases, the inner city hospital acquired a small suburban hospital, expanded it, transferred the tertiary services from the inner city facility and then closed the inner city facility. This is obviously an attempt to capture more of the affluent suburban market that is currently not coming to the old inner city hospitals.

Hospital Beds

Ohio has experienced a decline in the number of hospital beds since the 1995 deregulation from certificate of need. As shown below, total hospital beds at the end of 2000 had decreased by 5,456. Most of this decrease is a direct result of the closures of the large urban hospitals discussed above.

Type of bed	Before deregulation	December 2000
Special care	3,284	3,097
Med/surg	31,331	27,256
Obstetrics	2,715	2,462
Pediatric	2,808	2,649
Psychiatric	3,610	3,266
Rehab	1,618	1,790
Alcohol	1,530	928
Burn	111	103
Total	47,007	41,551

***NOTE: The total bed numbers shown at the end of December 2000 here and the closures and openings of beds (above) do not precisely match due to the different time periods from which the two sets of numbers were derived. Also, bed numbers in both listings exclude nursery beds and SNF beds.**

Cardiac Services

Cardiac catheterization and open heart surgery were deregulated effective March 1, 1998. Ohio law currently prohibits cath labs and open heart surgery unless performed in a hospital. As of September 2001, the following statistics apply to cardiac services.

	Before deregulation	After deregulation
Number of Ohio hospitals*	190	173
Hospitals with cardiac cath	86 (42%)	94 (54%)
Hospitals with open heart surgery	38 (20%)	50 (29%)

***Includes only hospitals with medical/surgical capabilities and excludes psychiatric and other specialty hospitals**

Imaging

MRI's located in an existing hospital were deregulated as of May, 1995. Freestanding diagnostic imaging centers (a center which includes either an MRI or a CT scanner or both) were deregulated in MSA areas as of May 1, 1996 and in rural areas as of May 1, 1997. Immediately before deregulation, the Department of Health recognized 23 non-hospital-based mobile or freestanding MRI's in Ohio. As of July 1999, the Department listed 126 non-hospital-based mobile or freestanding MRI's. Since July 1999, another 65 notices of intent have been filed for additional MRI's.

Prior to deregulation, there were 35 hospitals that maintained in-hospital MRI's. Since deregulation, virtually every Ohio hospital of any size now has an in-house MRI.

Radiation Therapy

Freestanding radiation therapy facilities and radiation therapy programs in hospitals were deregulated in March of 1998. Prior to deregulation, there were approximately 10 freestanding (non-hospital based) radiation therapy facilities in Ohio. The Department of Health in July 1999 listed 28 such facilities and an additional 6 notice of intent for freestanding radiation therapy facilities have been filed since July 1999. It is difficult to know how many hospitals maintained radiation therapy services prior to deregulation, but only two hospitals have added the service since deregulation.

Ambulatory surgery facilities

This is an area of the high activity and the most local contention. ASF's have been deregulated in MSA areas since May 1, 1996 and in rural areas since May 1, 1997. An ASF is defined as any place where outpatient surgery is performed that is not in the same building where inpatient services are rendered. In 1995 prior to deregulation, the Department of Health listed 31 ambulatory surgery facilities in Ohio. As of the end of August 2001, there are 186 such facilities actually operating in Ohio or under construction. Of these 186, approximately 30 are eye surgery only facilities.

The vast majority of the new ASF's are physician owned and operated, although there are some chain operations as well. A somewhat hidden result of the certificate of need deregulation is the effect that physician owned ASF's or the threat of a physician owned ASF has had on the smaller communities. In several one and two hospital towns, the physicians have approached the hospital with their plan to build an ASF and propose to "back-off" from the project only if the hospital will use its capital to build the facility and let the physicians have a large share of the profits or if the hospital will give the physicians more management control of the hospital. This has had the effect of pitting hospitals against

physicians in several Ohio communities with some rather unpleasant results. Obviously, the hospital does not want to build an ASF for physicians' profit; on the other hand the hospital cannot afford to lose much outpatient surgical business and hope to survive. Some hospitals and physicians have agreed to joint venture ASFs; other hospitals are toughing it out and have threatened to revoke staff privileges against any physician that invests in a competitor operation with the hospital. This remains the most difficult problem with the deregulation of CON.

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Website information: **http://www.bricker.com/publications/articles/71.asp**

Linda Miller

From: Rep. Peggy Wilson
Sent: Monday, March 27, 2006 1:13 PM
To: linda_miller@legis.state.ak.us
Subject: FW: *****SPAM***** Fiscal Note Analysis- HB 287
Attachments: Thoughts on fiscal note for Alaska.pdf

From: Jermey Hayes [mailto:jhayes@admin.apcak.net]
Sent: Monday, March 27, 2006 12:51 PM
To: Rep. Peggy Wilson; Rep. Tom Anderson; Rep. Lesil McGuire; Rep. Berta Gardner; Rep. Sharon Cissna
Subject: *****SPAM***** Fiscal Note Analysis- HB 287

Representatives—

The fiscal note attached to HB 287 was analyzed by one of the countries leading experts on CON policy out of Washington State by the name of John Barnes. He is a policy analyst and the author of a January 2006 study and Policy Brief which is being cited as the most credible and recent data available on Certificate of Need policy. I've attached his response to the fiscal note on HB 287 to this e-mail correspondence. There is a hearing on HB 287 scheduled for tomorrow at 3:00 PM and I feel this is important material to digest beforehand. Thank you kindly for your time, and have a wonderful day!

Jeremy Hayes
Assistant Administrator
Advanced Medical Centers of Alaska

Pain Management - Sports Medicine & Rehab - Health Psychology

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Note to Patients regarding e-mail transmissions: Using the Internet- The Choice is Yours.
There are a number of risks you should consider before using email to communicate with us: email can be circulated, forwarded and stored in numerous paper and electronic files; email can be intercepted, altered, forwarded or used without authorization or detection; email senders can easily misaddress an email; backup copies of email may exist even after the sender deletes the email; employers and online services have the right to inspect email transmitted through their systems; email is easier to falsify than handwritten or signed documents; and email can be used to introduce viruses into computer systems. Confidentiality of Internet communications cannot be guaranteed by Advanced Pain Centers of Alaska. Use of the Internet is solely at your own risk.

John Barnes, Policy Analyst
jbarnes@washingtonpolicy.org

Concerns regarding the fiscal note for Alaska's HB 287 (2006)

Scaling Down Certificate of Need Requirements

- Too little explanation of the fiscal note estimates. How *exactly* did they arrive at these numbers? This is especially important if the crux of the argument against scaling down CON laws is the fiscal impact on the state.

- The department predicts $2.7 million in expenditures for Cardiac Hospitals starting in FY2010, but admits there have not been any specific inquiries for such facilities.

- The department admits uncertainty with the numbers for various reasons, but insists their estimates are "conservative." This does not make sense. If this is true uncertainty, then their estimates could be high as well.

- In general, the department makes estimates and projections for several years down the road. You cannot assume this to be accurate. Financial estimates for that far out are laden with problems because of shifting variables and unpredictable circumstances. The general unreliability of state projections and projection methodologies is a large reason why CON laws do not help control health care costs. You cannot centrally-plan for the present or the near future, much less 6 or 7 years down the road.

- The department makes a $2.7 million projection for Orthopedic Hospitals without providing demonstration of interest. They state simply that "it is only a matter of time before they move to Alaska," and make a projection for FY2012. Fiscal notes ought not be based on the *supposed* inevitability of anything, and a projection for 6 or 7 years down the road is informed speculation at best due to shifting economic and demographic factors.

- In general, the calculation methodology (that which can be seen, at any rate) is suspect. The department is basing its estimation of facilities that would be built in a post-CON era on letters of intent and applications received in the past. But letters and applications are filed with the understanding that CON may not be granted. They are filed in an attempt to enter a market where providers are insulated from competition, where success is much more assured. When there is no CON barrier, providers have to be more careful in deciding to enter the market, and some who filed letters and applications would not actually proceed with projects because the likelihood for success changed. **You cannot assume that the number of letters and applications reflect the likely number of new facilities.**

- The fiscal note is based on the *assumption* that a massive supply surge will follow a CON downscaling. That is not necessarily true. A 1998 empirical study published in *Journal of Health Politics, Policy, and Law* examined health spending between the late 1970s and 1993

and found that in states that repealed CON laws, there was no surge in health spending.[1] This evidence contradicts the fiscal note's projections. [If this surge does occur, it will reflect the fact that the supply was abnormally depressed due to CON in the first place. In the long run Alaska will experience a leveling off of supply that reflects true demand.]

- A 2003 study by three leading authorities in the field of health policy found that aggregate state-level data from 1981 through 1998 shows states that repealed their CON and moratorium laws had no significant growth in either nursing home or long-term care Medicaid expenditures.[2] This evidence contradicts the fiscal note's projections, and *even if these facilities are not included in the bill, this evidence calls into question the department's methodology for fiscal impact and its assumptions in general.*

- Fiscal note numbers do not reflect the potential for cost reduction in the aftermath of CON downscaling. CON laws curtail services and facilities, often forcing patients into more expensive substitutes, thus increasing costs for patients or third-party payers. EXAMPLE: if nursing home beds are not available, the discharge of patients from more expensive hospital beds may be delayed or patients may be forced to use a more expensive nursing home.

- Fiscal note numbers do not take into account the potential for savings through reduced administrative costs, less personnel time, etc. If less time and resources are being spent running CON, that's money saved. This is true for business as well. Many businesses have entire departments devoted to just the CON process.

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[1] Christopher Conover and Frank Sloan. "Does removing certificate-of-need regulations lead to a surge in health care spending?" *Journal of Health Politics, Policy, and Law*, Vol. 23, Issue 3.

[2] David C. Grabowski, Robert L. Ohsfeldt, and Michael A. Morrisey. "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures," *Inquiry* 40 (Summer 2003): 146-157.

Linda Miller

From: Kala Ladenheim [kala.ladenheim@ncsl.org]
Sent: Wednesday, March 22, 2006 1:19 PM
To: Linda Miller
Cc: paul deyoung
Subject: Fw: Certificate of Need information

Hi Linda,
I apologize, this got pushed back from Paul's plate by a competing deadline. Here is some preliminary material. The short version is that depending on the study you look at (see below) prices may go up, down or stay the same--mostly, there doesn't seem to be much effect one way or another. There seems to be a long-standing consensus that CoN isn't very effective, which would mean they don't do any good but also don't do harm. Hospital CoN has been critiqued as a way for dominant providers to maintain control over a market and raise barriers to entry. These days there seem to be so many other anticompetitive forces--consolidation of markets, concentration of providers into chains, privatization and conversion of not-for-profits--that would have a greater impact.

CoN for hospitals fell out of favor in the 1990s when market competition via managed care was seen as a way to exert fiscal discipline. However, CoN and related practices continue to be a part of the discussion around reconfiguring long term care delivery systems (which is why I cite a couple of items on this issue below), expensive diagnostic technologies, and other delivery system changes.

I've also heard discussions that CoN is redundant because capital markets will exercise necessary constraint on excess growth in their practice of due diligence. However, the literature on induced demand does seem to be strong--that if services are available, people are likely to be encouraged to use them even beyond the point of medical necessity. This suggests that if there is a public hospital bonding authority you may want to have some sort of CoN-like review not as a regulator but as a prudent investor.

The most detailed recent study I found suggested that costs and benefits as a result of the CoN regulation were a wash, but that the cost of the regulatory process itself was high (both to regulators and the industry), tipping scales against CoN. That is not the same as saying that markets became more efficient when it was removed--am not aware of any studies that suggest that.

Paul may be able to follow up with more detail and more specific studies.

Here are a couple of other considerations:

One thing to consider is that CON is actually very different from state to state in terms of which providers are affected for what items; the impact will also be affected by the kind of market the state has. Some states mostly regulate nursing home supply, for example, while others focus on big ticket technologies like high end imaging. Studies may be inconclusive because CoN helps some markets function and hurts others.

A criticism of the earliest study was that it ignored something called "endogeneity." The terms means that the cause and effect are intermingled, and the thing that you think is the result of the policy change (prices going up) is also the thing that led you enact the policy. So, you have to be careful to make sure your are not measuring a cause or a general background trend when you think you are measuring an effect.

An example of endogeneity would be: states are likelier to pass a CoN law if they have a lot of providers who compete to "induce demand", for example, a technological arms race. Thus, if too many hospitals buy MRIs, costs in the community are higher because they do more MRIs than are strictly medically indicated to pay for equipment.. These are expensive markets, with providers competing to induce demand and steeper trendlines than other markets. A comparison with other states may suggest that CoN raises prices, especially if their trends are compared with rural state s with mostly sole community providers where prices are more influenced by the overall economy and community benefit demands. But what may be getting measured is underlying differences that are part of the reason for the law being introduced, not differences that result from the law. OOHard to sort it out!!

Here are some of the arguments being made on both sides of the question. The tone is pretty heated on both sides, which to me is always a sign that there is more ideology than information out there.

----- Original Message -----
From: Kala Ladenheim
To: Kala Ladenheim ; paul deyoung
Cc: Tara Lubin ; paul deyoung
Sent: Monday, March 20, 2006 5:41 PM
Subject: Re: Certificate of Need information

Some items that may be useful.

Apparantly this round is triggered by a 2004 FTC/DoJ paper, http://www.ftc.gov/opa/2004/07/healthcarerpt.htm critiqued here by the CoN trade association as being based on a mix of wishful thinking by industry, dismissal of recent research and reliance on 20-year-old flawed studies.. http://www.ahpanet.org/images/AHPAcritiqueFTC.pdf

This looks like a good literature review. Overall: neutral impact both going an and taking out, main fiscal impact is due to not having regulation--the regulatory costs themselves. Both financial and quality impacts were seen going in both directions.
http://www.hpolicy.duke.edu/cyberexchange/Regulate/CHSR/HTMLs/F9-Cert%20of%20Need.htm

- *Government Regulatory Costs.* Total staffing for CON agencies by state are reported in DHHS (1986).
- *Indirect Costs: Impact on Health Expenditures.* Using HCFA time series cross section state level per capita spending data for 1969, 1972 and 1976-1982, Lanning, Morrisey and Ohsfeldt found that CON was associated both with an increase in per capita hospital spending (20.6 percent) and per capita spending on other health services (9.0 percent), for a net increase of 13.6 percent in health spending overall. **Using the same HCFA data from 1980-1993, Conover and Sloan (1998) found that CON had a long run effect of reducing hospital spending per capita by 5 percent, but there was no significant impact on overall health spending per capita. In a recent unpublished update that makes use of these data for the 1980-1998 model, Sloan and Conover find that dropping CON for acute care services had no significant effect on total per capita health spending, components (hospital and physician spending) or Medicare spending per eligible. Stringent CON was associated with a statistically significant reduction in hospital spending, but not in overall per capita expenditures, along with a –1.8 percent decline in Medicare spending per eligible.**

CoN isn't one-dimensional so cost impacts probably aren't either. Here's a good run-down of different types of regulation in CoN , prepared for the Illinois health planning board. http://www.idph.state.il.us/about/hfpb/GSU%20CON%20Assessment%20Summary.pdf

GA CON study commission--might be worthwhile to find some of theitems cited
http://www.gcn.org/Services/PublicPolicy/PolicyUpdates2005State/CertificateofNeedStudyCommissionUpdate.aspx
http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.363/DC1

The Effects of CON **Repeal** on Medicaid Nursing Home and Long-Term ...
It is widely known that **certificate of need** (CON) programs have been ... 1987; The **Impact** of State Medicaid Nursing Home Policies on Utilization and ...
www.inquiryjournalonline.org/inqronline/?request=get-document& issn=0046-9580&volume=040&issue... - Similar pages

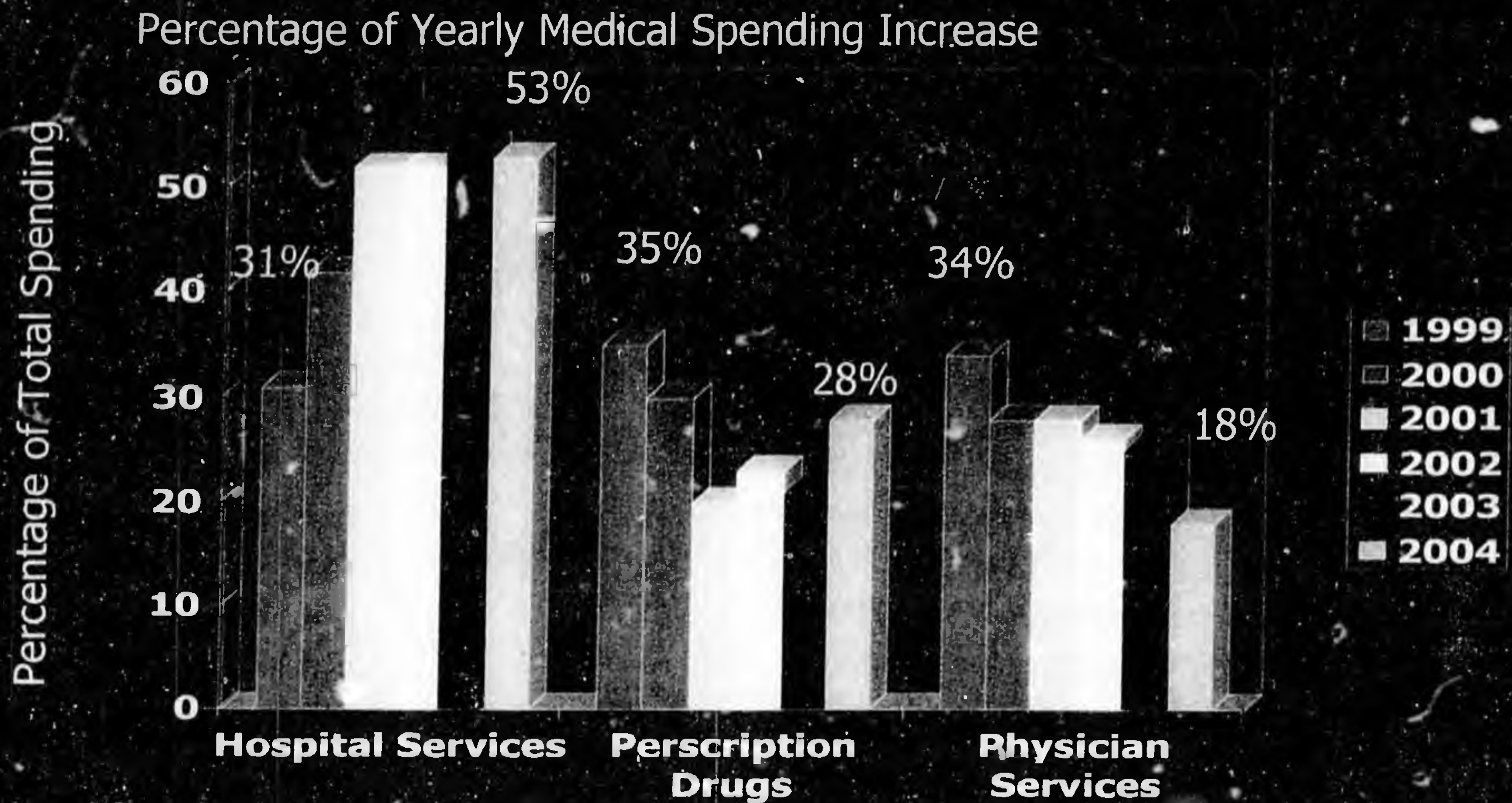
----- Original Message -----
From: Kala Ladenheim
To: paul deyoung
Cc: Tara Lubin
Sent: Friday, March 17, 2006 5:18 PM
Subject: Fw: Certificate of Need information

Can you do this info request? Touch base with Tara and me.
----- Original Message -----
From: Linda Miller
To: kala.ladenheim@ncsl.org

Sent: Friday, March 17, 2006 12:44 PM
Subject: Certificate of Need information

Hello Kala,
I am the HESS Committee Aide for Rep. Peggy Wilson and she has requested information on the the Certificate of Need. She specifically would like to know if in states where they have repealed the CON if the costs have went down. Any information you can provide to us would be very helpful. She will be hearing a CON bill in her HESS Committee on Tuesday, March 28th. Thanks for your help.
Linda Miller, MSW
HESS Committee Aide
Office of Representative Peggy Wilson
Alaska State Legislature

Spending Growth Continues To Be Dominated by Hospital Services



Employee Benefit Research Institute, Strunk, Gabel and Ginsburg, December 2004, Center for Studying Health System Change www.hschange.org

Form 990

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

▶ The organization may have to use a copy of this return to satisfy state reporting requirements

OMB No 1545-0047

2003

Open to Public Inspection

A For the 2003 calendar year, or tax year beginning , and ending

B Check if applicable: Address change, Name change, Initial return, Final return, Amended return, Application pending

C Name of organization: GREATER FAIRBANKS COMMUNITY HOSPITAL FOUNDATION, INC

Number and street (or P O box if mail is not delivered to street address): P O. BOX 71396 — Room/suite

City or town: FAIRBANKS — State or country: AK — ZIP + 4: 99707

D Employer identification number: 92-0035784

E Telephone number: 907-452-2955

F Accounting method: ☐ Cash ☒ Accrual ☐ Other (specify) ▶

• Section 501(c)(3) organizations and 4947(a)(1) nonexempt charitable trusts must attach a completed Schedule A (Form 990 or 990-EZ).

H and I are not applicable to section 527 organizations.

H(a) Is this a group return for affiliates? ☐ Yes ☒ No

H(b) If "Yes," enter number of affiliates ▶

H(c) Are all affiliates included? ☐ Yes ☐ No (If "No," attach a list See instructions.)

H(d) Is this a separate return filed by an organization covered by a group ruling? ☐ Yes ☒ No

I Group Exemption Number ▶

G Website: ▶ N/A

J Organization type (check only one) ▶ ☒ 501(c) (3) ◀ (insert no) ☐ 4947(a)(1) or ☐ 527

K Check here ▶ ☐ if the organization's gross receipts are normally not more than $25,000 The organization need not file a return with the IRS, but if the organization received a Form 990 Package in the mail, it should file a return without financial data Some states require a complete return.

M Check ▶ ☐ if the organization is not required to attach Sch B (Form 990, 990-EZ, or 990-PF)

L Gross receipts Add lines 6b, 8b, 9b, and 10b to line 12 ▶ 21,292,746

Part I Revenue, Expenses, and Changes in Net Assets or Fund Balances (See page 18 of the instructions)

Line	Description		Amount	Line	Total
1	Contributions, gifts, grants, and similar amounts received:				
a	Direct public support	1a	282,358		
b	Indirect public support	1b			
c	Government contributions (grants)	1c			
d	Total (add lines 1a through 1c) (cash $ 219,528 noncash $ 62,830)			1d	282,358
2	Program service revenue including government fees and contracts (from Part VII, line 93)			2	16,409,542
3	Membership dues and assessments			3	0
4	Interest on savings and temporary cash investments			4	89,847
5	Dividends and interest from securities			5	4,366,837
6a	Gross rents	6a			
b	Less: rental expenses	6b			
c	Net rental income or (loss) (subtract line 6b from line 6a)			6c	0
7	Other investment income (describe ▶ INTEREST INCOME)			7	132,668

Line	Description	(A) Securities		(B) Other
8a	Gross amount from sales of assets other than inventory	0	8a	11,125
b	Less: cost or other basis and sales expenses	0	8b	475,408
c	Gain or (loss) (attach schedule)	0	8c	-464,283

Line	Description		Amount	Line	Total
d	Net gain or (loss) (combine line 8c, columns (A) and (B))			8d	-464,283
9	Special events and activities (attach schedule) If any amount is from gaming, check here ▶ ☐				
a	Gross revenue (not including $ 282,358 of contributions reported on line 1a)	9a	0		
b	Less: direct expenses other than fundraising expenses	9b	0		
c	Net income or (loss) from special events (subtract line 9b from line 9a)			9c	0
10a	Gross sales of inventory, less returns and allowances	10a			
b	Less: cost of goods sold	10b			
c	Gross profit or (loss) from sales of inventory (attach schedule) (subtract line 10b from line 10a)			10c	0
11	Other revenue (from Part VII, line 103)			11	569
12	Total revenue (add lines 1d, 2, 3, 4, 5, 6c, 7, 8d, 9c, 10c, and 11)			12	20,817,338
13	Program services (from line 44, column (B))			13	8,497,445
14	Management and general (from line 44, column (C))			14	483,699
15	Fundraising (from line 44, column (D))			15	3,988
16	Payments to affiliates (attach schedule)			16	0
17	Total expenses (add lines 16 and 44, column (A))			17	8,985,132
18	Excess or (deficit) for the year (subtract line 17 from line 12)			18	11,832,206
19	Net assets or fund balances at beginning of year (from line 73, column (A))			19	201,355,981
20	Other changes in net assets or fund balances (attach explanation)			20	1,348,996
21	Net assets or fund balances at end of year (combine lines 18, 19, and 20)			21	214,537,183

RECEIVED
AUG 2 0 2004
OGDEN, UT

Profile

NOTES

The hospital's most recent cost reporting period is for their period ending 12/31/2004.
Inpatient claims data are for federal fiscal year ending 09/30/2004.
OP claims data are for calendar year ending 12/31/2004.
Data from other sources are described within headings.
Errata: Please notify us by email of any corrections or updates.

Identification and Characteristics

Last updated 11/09/2005 / Definitions

Name and Address: **Providence Alaska Medical Center**
3200 Providence Drive
Anchorage, AK 99508

Telephone Number: (907) 562-2211

Hospital Website: www.providence.org/alaska/pamc/defa...

Medicare Provider ID: 020001

Type of Facility: Short Term Acute Care

Type of Control: Voluntary Nonprofit, Church

Total Staffed Beds: 354

Total Patient Revenue: $715,350,595

Total Discharges: 15,569

Total Patient Days: 89,412

Clinical Services

Definitions

Cardiovascular Services
- Cardiac Rehab
- Cardiac Cath Lab
- Coronary Interventions
- Cardiac Surgery
- Vascular Surgery
- Vascular Intervention

Emergency Services
- Emergency Department

Neurosciences
- Electroencephalography (EEG)
- Sleep Studies

Oncology Services
- ACS/CoC Approved Cancer Program

Rehabilitation Therapies
- Physical Therapy

Wound Care
- Wound Care

Other Services
- Hemodialysis
- Home Health
- Inpatient Surgery
- Obstetrics

Subprovider Units
- Rehabilitation

Special Care
- Intensive Care Unit (ICU)

	Genitourinary Procedures	[illegible]	[illegible]	[illegible]
ɔ	Cannula/Access Device Procedures	94	$1,837	$1,431

eds and Patient Days by Unit

efinitions

	Available Beds	Inpatient Days
IOSPITAL (including swing beds)		
Routine Services	279	67,075
Special Care	75	17,690
Nursery	0	4,647
Total Hospital	354	89,412

inancial Statistics

efinitions

	$	%
Gross Patient Revenue	$715,350,595	96.00
Non-Patient Revenue	$29,779,693	4.00
Total Revenue	$745,130,288	
Net Income (or Loss)	$23,615,174	3.17

About the company / Site Map / Email: support@ahd.com / No SPAM
All users should read notice, disclaimer, and agreement.
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