HB

337/345

(FILE 2)

- Leave Financial thresholds as currently defined and request clarification on items below, as noted:

Equipment Thresholds:

Recommendation: state needs to clarify definition of equipment – differentiate between facility equipment and medical equipment (#2 on page 18) via an advisory group (see below):

Advisory group	Clearly define the differences between which items require CON • Refurbished equipment • Novel scope of services (possible CON) • Replacement equipment a. Same purpose b. New equipment

Facilities Thresholds:

Recommendation: state needs to clarify definition of facilities

Advisory group	Clearly define the differences between which items require CON • Refurbished, remodeling existing facilities, renovating and/or repairing existing facilities for same use, same scope of services– no added services • Novel scope of services • Replacement facilities a. Same purpose b. New facilities

- State needs to fund a data driven process in order to avoid a litigious CON environment.
- Ambulatory Surgery Centers need to be defined in State Statutes or Regulations.

- Increase Consistency in processes and timelines to eliminate loopholes.
- Level the playing field and create consistency in the POE application process. Everyone wants to level the playing field. Make the process crystal clear with rules for the Commissioner to follow.
- Ambulatory Surgery Centers require CON process
- Ultrasound Services are not included in CON
- All facilities and equipment above the threshold must request for POE letter of exemption

V. Areas of Non-Consensus

Definitions for the Physician Office Exemption (POE) were the most controversial topic throughout all the sessions. The POE was by far the biggest issue for the group and was repeatedly discussed in varying formats. The committee revisited this area in varying approaches with evolving dialog at each turn. This was reflected in the progression of numerous votes that did not reach consensus on the POE exemption definitions below. **However, the committee eventually reached consensus on the final vote for the POE during the last session (See IV. Physician Office Exemption below).**

The following represents the areas that were discussed in parsing the disputed topics of POE and radiology definition for POE. The lack of any consensus in these questions shows the diametrically opposed positions and interests that have led to the current spate of litigation.

Two additional areas of topical discussion included:

1) Expansion of imaging services in the state by entities other than hospitals

2) Development of free standing ambulatory surgery centers. (eventually reached high consensus that Ambulatory Surgery centers to be included in the CON)

While discussed separately, both issues had common points.

Some committee members did not want physician groups opening surgery centers "to treat their own patients" but were content to let any individual physician groups acquire any imaging equipment, to treat "their own patients".

Imaging specialists seemed very concerned about the unfettered expansion of imaging equipment by physicians who, until recently, never directly used or owned this equipment, were unfamiliar and untrained in the equipments appropriate and safe utilization.

The committee voted during the first session (October 29-30, 2007) on how to handle the physician office exemption issue and ranked them in the following order:

- Mitigate – 24.7%
- Accommodate – 20.8%
- Transfer – 19.5%

- Eliminate – 18.2%
- Avoid – 16.9%

No Consensus was reached in determining how to approach the POE issue.

Initially, No Consensus was reached initially in determining whether other partners besides hospitals be allowed for POE exemptions. Vote was split 50-50.

Initially, No Consensus was reached on whether other partners besides hospitals be allowed for P.O. exemptions. Vote was split 45% yes against 55% no. (this was re-voted on again later)

No Consensus was reached on whether physician ownership should be 100% for P.O. exemption from the CON process. 35% yes, 65% no (this was voted on again later with high consensus).

The group tried again to determine what percentage of ownership should physician's have for a P.O.E. (physician's office exemption). This time the committee was given 5 choices and results were split as listed below:

- At least 40% - 8 votes
- Greater than 50% - 4 votes
- 65% - 2 votes
- 75% - 4 votes
- 85% - 2 votes

No Consensus was reached on whether anyone can be a minority partner in a physician's office. Vote was split 52.63% vs. 47.37%.

No Consensus was reached when the committee tried to rank (in order from highest to lowest) the percentage for physician owned, when given the following choices, with results below:

- Physician owned 100% - 6 votes
- Physician owned with a hospital – 8 votes
- Physician with anyone – 6 votes

No Consensus was reached when the physician owned percentage question was changed to allow only 2 choices:

- Physician owned 100% - 13 votes
- Physician with anyone – 7 votes

No Consensus was reached for E&M Physician (non radiologist) 100% Physician owned. Vote was split 60% yes, 40% no.

No Consensus was reached for Radiologist – majority ownership with anyone. Split vote: 60% yes, 40% no.

No Consensus was reached when asked to: discuss small and large communities together. Split vote with 57.89% yes and 42.11% no.

No Consensus was reached: Discuss E&M and Radiology separately? Split vote: 52.63% yes and 47.37% no.

No Consensus was reached on the following question:

Physician ownership E&M and Radiologists – large communities:
75% - 8 votes (=38.10%)
100% - 13 votes (=61.90 %)

No Consensus was reached for:

POE – large communities: Split vote with 100% physician owned – 60% and partner with anyone 40%.

No Consensus was reached for non-radiologists – large communities: 100% owned received 57.89% of the votes and partner with anyone received 42.11% of votes.

VI. Physician Office Exemption: Final Consensus

Despite the opposing positions of many of the committee members in approaching the POE issue there was a general consensus that the exemption was a loophole as written and needed to be amended in order to protect interests. The committee wrestled the most with who could own a physician's office. The group also asked who shouldn't be a partner? They agreed that publicly traded companies cannot be a physician's office partner. A turning point on the last day was when one committee member described how the POE had worked against their hospital and that if it could happen to them it could also happen to anyone. After protracted discussion and reversing itself on ownership percentages the committee reached consensus that in order to qualify for the POE the physician office must be 100% owned by physicians (71.43%, YES). A higher degree of consensus would have been obtainable if those committee members with a vested financial interest in the vote were exempted from voting.

A high consensus was obtained for recommending the definitions for qualifying for the POE (derived from medicare guidelines) and amended by the committee, be as follows;

INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs)
All suppliers that perform diagnostic tests, other than clinical laboratory or pathology tests, and are required to enroll as an IDTF. Not all suppliers that perform diagnostic tests are required to enroll as an IDTF. Generally, an entity can bill for the technical component of the diagnostic tests without an IDTF enrollment if it has the following characteristics:

- A physician practice that is owned 100%;
- A facility that primarily bills for physician services (e.g., evaluation and management (E&M codes) and not for diagnostic tests;
- A facility that furnished diagnostic tests primarily to patients who medical conditions are being treated or managed on an ongoing basis by one or more physicians in the practice;
- The diagnostic tests are performed and interpreted at the same location where the practice physicians also treat patients for their medical conditions.

However, if a substantial portion of the facility's business involves the performance of diagnostic tests, the diagnostic testing services may be sufficiently separate business to require enrollment as an IDTF. In that case, the physician or physician group practice can continue to be enrolled as a physician or physician group practice but are also required to enroll as an IDTF.

Diagnostic Radiology – Many diagnostic tests are radiological procedures that require the professional services of a radiologist. We recognize that a radiologist's practice is generally different from those of other physicians because radiologists usually do not bill E&M codes or treat a patient's medical condition on an ongoing basis. A radiologist or group practice of radiologists is not necessarily required to enroll as an IDTF. A radiologist or group of radiologists, are not required to enroll as an IDTF if all of the following conditions are met:

- The practice is owned 100% by radiologists, Physicians whose primary practice is Diagnostic Imaging and occasionally perform evaluation;

- The owning radiologist(s) and any employed or contracted radiologist(s) regularly perform physician services (e.g., test interpretations) at the location where the diagnostic tests are performed (>70% of tests);
- The facility does not usually purchase interpretations (generally interpreted <30% of tests);
- The billing patterns of the enrolled facility indicate that the facility is not primarily a testing facility and that it was organized to provide the professional services of radiologists (e.g., (1) the enrolled facility should not be billing for a significant number of purchased interpretations, (2) the facility should rarely bill for the technical component of a diagnostic test, (3) the facility should bill for substantial percentage (at least 70%) of all interpretations of the diagnostic tests performed by the practice), and
- The facility ordinarily bills globally

VII. Other Committee Recommendations

The following recommendations are a combination of general committee member comments and submitted recommendations by committee members

The Alaska State Medical Association (ASMA), in a letter dated November 6, 2007 to Karleen Jackson and Kevin Henderson, the House of Delegates (ASMA's policy making body) states that they support and advocate for the elimination of the entire CON program, except in small communities in Alaska. The reason they support the program only in small communities is because "Apparently, the State is not collecting nor analyzing sufficient data to show that the CON program has met its objectives."

The committee requests the state to define "excessive" and "need" more clearly in the regulations.

Community populations should be counted and need should be determined consistently (i.e.; count military/Native consistently the same). The population formula should be subject to revalidation if/when the population changes.

The committee would also like to see a state health plan/vision developed.

CON Process:

- Standards should be used as decision criteria
- Should be a data driven process
- A letter should be sent to CON P.O.E. grantees requiring them to submit data (# of patients served, etc.)
- Needs should be based on data, according to community (need community plans)
- Take market forces into consideration: can hospitals compete in the geographic area?
- Consider the capacity of each community
- CON grantees should be subject to revalidation based on data/numbers/need and changes
- The CON process should specify a window of response for other (competing) CON applications.

Administrative Hearing Process Recommendations:

- Needs to be more timely (90 days) *Note: Lawsuits start after the state decision or if it is taking too long.*

To curb lawsuits;

1. **Provide clear definitions** of the following:
    - Physician offices (see recommended language);
    - Define a small community? (Population) Population and capacity need to be looked at, in regard to the process.

2. **Get and Provide accurate data**, The State needs to provide better data and statistics according to geographical area (from discussion specific to definition of POE in CON process)

3. **Make administrative processes more timely**

4. **Create a consistent review process**

VIII. Attachments

Notes from sessions

Raw Consensor data in excel format

Session 1: October 29, 2007

ESTABLISHED GROUND RULES (which also apply to the rest of the committee meetings):

- Seek first to understand then to be understood
- Speak directly to your point
- Respect everyone's choices as right for them
- Spend 10% of your time identifying concerns & issues, 90% of your time identifying options & solutions
- Focus on choices and consequences versus right and wrong
- All Voices count
- Follow facilitator instructions

Decision Considerations:

Quality & Safety
Cost
Access
Utilization
Purpose(s)
Public Duty
Level playing field

HOPES

Something we can all work with
Bring historical perspective current
From litigation to cooperation
Find common ground
Recognizing behavioral health needs
Balanced
Clarity/working agreements
Access
Unique markets:
geographic/demographic
Fairness: patients/providers
Alignment to demographic similar states
Reduce litigation
Level playing field
Quality, access, safety

CONCERNS

Certificate process not working
Current uncertainty/frequency of changes
Complexity
Diversity of interests
Anti-competitive
Competitive vs. non-competitive
Barriers

Preliminary Topics of Interest (that were brought up-for open space breakout groups)

Statutes
Scope
CON vs. No CON - Elimination of CON
What is competition in medical field?
What is CON accomplishing?

Purpose of CON?
Public duty of health care providers
Regulations
Quality: affected by what? Measured how? What is quality?
Cost: effective at controlling cost?
Definition of Cost: cost/charge (per unit? Global? By utilization?)
Applying for CON

OPEN SPACE BREAKOUT TOPICS (actual process):
~~Eliminate CON fully~~ (CONSENSUS not to eliminate CON fully)
~~Keep it as is~~ (CONSENSUS that CON cannot stay as is)
Modify CON substantially (more robust/add/clarify)
Eliminate CON mostly (change scope to regulate only a few fields)

RESULTS OF OPEN SPACE BREAKOUT GROUPS

ELIMINATE FULLY:
Revise first then decide if want to eliminate
Eliminating CON eliminates contributions to non contributing services
High margin vs. low margin
Mid size markets hurt even more (selective – high payor services)
Would aid in selective high payors recruitment / retention
Doesn't aid in recruitment / retention
A fair and transparent process
AK: Some of highest healthcare costs in nation (system broke)
Unfettered free market (does not exit, can be destructive)
Hospitals not free to compete
Population dependent
Strains on human resources
Creates open competition
Private sector serves public duty 2%-10%
Will bleed away from hospitals, could cause raised prices
Any willing provider
Payors can contaminate free market
Jeopardize public trust to provide emergency and charity care proportionate to the community
CON does not contain costs

MODIFY SUBSTANTIALLY
Adequate resource and staff to service appropriately
Accurate need assessments (utilization, tracking, capacity calculation)
Populations (Native, military)
Less onerous Process (application)
Define c ality
Credentic ls

Clarification (IDTF, physician office, dollar threshold, CHS definitions vs. state definition, service, affected vs. non-affected parties)
Modification procedure
Review of new services and community(s)

ELIMINATE MOSTLY:
What vs. Who (What is services, ie MRI. Who is physician office, hospital and is a location)
Why – hospital vs. independent?
Physician rep comment: eliminate all but small geographic
Eliminate all except for psychiatric
Who's here? (representing field)
To do so would negatively impact full-service hospital's ability to provide care such as Emergency and charity care, proportionate to community size, but not as much so as "fully" eliminating CON
Geographic
Maintain psych, nursing homes, outpatient diagnostic – further define, surgery center, beds
ASCs – shouldn't require CON
Based on population size?
Increase threshold for requiring CON

What's In (for future discussions)

Health Care Facilities (tab 4 page 9) - CONSENSUS

- Private, municipal, state or federal hospital
- Psychiatric hospital
- Independent diagnostic testing facility
- Residential Psychiatric Treatment Center
- Tuberculosis hospital
- Skilled nursing facility
- Kidney disease treatment center
- Ambulatory Surgery Center

Radiation Therapy

Imaging

- PET
- MRI
- CT
- Mammography
- Nuclear Medicine
- Cath Labs

New Services
IDTF vs. Physician's Office
Thresholds

Session 1: Day 2 : October 30, 2007

The CON Committee agreed that quality was off the table for discussion.

Recommendations to the state:
The committee would like to ask the state to define "excessive" and "need" more clearly.
The committee would also like to view a state health plan/vision.

"Intermediate Care Facility": The committee decided to revisit this issue when the group discusses PROCESS in future meeting(s).

"Who" Discussion:

- Physicians
- Anyone who wants to provide a what
- Whose money is it?
- Type of organization
- Owner structure (who are they? How are they integrated?

The following was agreed upon by the committee at the end of the October 30, 2007 meeting by a show of hands:

What physician offices would be exempt?

- Not a facility
- Independent from hospital (financially & managerially)
- Appropriately licensed and certified
- Works within scope of practice

Radiation Therapy Discussion:
What would radiation therapy (out of a hospital) in a physician's office look like? (e.g., radiotherapy seed business)

- Independent of hospitals
- Work within scope of practice
- Multiple equipment types
- Majority ownership by physician or physician hospital
- Licensed by NRC or state certified
- Local presence by owners

*note: hospital ownership of radiology equipment was tabled to the next meeting

A show of hands at the end of the second day of the meeting determined the start for radiology definition would be:

Paragraphs one and two of the CMS handout and then add the second paragraph of Chakri's definition.

(the following two paragraphs are excerpts from Attachment 2 on page 55 of CMS 855B (11/2001) and the last section was added by the CON Negotiated Regulation Committee on 10/30/07)

INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs)
All suppliers that perform diagnostic tests, other than clinical laboratory or pathology tests, and are required to enroll as an IDTF must complete this attachment. CMS requires the information in this attachment to determine whether the enrolling supplier meets all IDTF standards. Not all suppliers that perform diagnostic tests are required to enroll as an IDTF. Generally, an entity can bill for the technical component of the diagnostic tests without an IDTF enrollment if it has the following characteristics:

- A physician practice that is owned, directly or indirectly, by one or more physicians or by a hospital;
- A facility that primarily bills for physician services (e.g., evaluation and management (E&M codes)) and not for diagnostic tests;
- A facility that furnished diagnostic tests primarily to patients who medical conditions are being treated or managed on an ongoing basis by one or more physicians in the practice;
- The diagnostic tests are performed and interpreted at the same location where the practice physicians also treat patients for their medical conditions.

Diagnostic Radiology – Many diagnostic tests are radiological procedures that require the professional services of a radiologist. We recognize that a radiologist's practice is generally different from those of other physicians because radiologists usually do not bill E&M codes or treat a patient's medical condition on an ongoing basis. A radiologist or group practice of radiologists is not necessarily required to enroll as an IDTF. A radiologist or group of radiologists, are not required to enroll as an IDTF it all of the following conditions are met:

- The practice is owned by radiologists, a hospital, or both;
- The owning radiologist(s) and any employed or contracted radiologist(s) regularly perform physician services (e.g., test interpretations) at the location where the diagnostic tests are performed;
- The billing patterns of the enrolled facility indicate that the facility is not primarily a testing facility and that it was organized to provide the professional services of radiologists (e.g., (1) the enrolled facility should not be billing for a significant number of purchased interpretations, (2) the facility should rarely bill for the technical component of a diagnostic test, (3) the facility

should bill for substantial percentage of all interpretations of the diagnostic tests performed by the practice), and

- A substantial majority of the radiological interpretations are performed at the practice location where the diagnostic tests are performed.

Paragraph to be added to CMS (recommended by CON Committee on 10/30/07):

Physicians whose primary practice is Diagnostic Imaging and occasionally perform evaluation

- The facility is owned by physicians, a hospital or both;
- Test interpretations are usually performed at the location where the diagnostic tests are performed (>70% of tests);
- The facility does not usually purchase interpretations (generally interpreted <30% of tests;
- The facility ordinarily bills globally

Sheraton Hotel, Josephine's Gallery
Session 2: November 13 & 14, 2007

Committee Members Present November 13, 2007:

1. Mark Wade
2. Robert Bridges
3. Ward Hinger
4. Jeremy Hayes
5. Victor Joseph
6. Shawn Morrow
7. Rod Betit
8. Michael Zielaskiewkz
9. Paul Morris (for Ed Lamb)
10. Mike Powers
11. Jeff Kinion
12. Brad Cruz
13. Joel Gilbertson
14. Bruce Jayne
15. James Shill
16. Creed Marnikunian
17. Jay Butler
18. Jason Paret
19. Baxter Burton

ESTABLISHED GROUND RULES (applies to all committee meetings):

- Seek first to understand then to be understood
- Speak directly to your point
- Respect everyone's choices as right for them
- Spend 10% of your time identifying concerns & issues, 90% of your time identifying options & solutions
- Focus on choices and consequences versus right and wrong
- All Voices count
- Follow facilitator instructions

Decision Considerations:
Will it reduce litigation?
Will it assist in cost containment?
Will it assist in access?
Does it level the playing field?

HOPES
Discuss Ambulatory Surgery Centers

CONCERNS
CON ends up in court and judges end up making decisions: to date committee has not discussed

NOTES FROM CON SESSION 2: *November 13, 2007*

Clarification requested regarding Tribal Clinics and how CON may affect them.

- State should be aligned with federal in regard to Tribal facilities
- Need clarity or specific language regarding Tribal Facilities included in CON for planning purposes

AGENDA ITEMS TO DISCUSS

(consensus prioritization – voted on with results of prioritization below)

1. P.O. Exemption (22%)
2. Thresholds (19%) -
3. Process tied with Enforcement of CON (16% each)
4. Ambulatory Surgery Centers (14%)
5. Tribal Clinics (13%)

RADIOLOGY / P.O. EXEMPTION

<u>P.O. Exemption</u>

- ✓ Financial Interest / Actively Participating
- ✓ Directed by Owner Physicians

- ➢ Should hospital ownership be allowed for P.O. Exemption?
- ➢ What does majority owned mean? (>70% - consensus)
- ➢ Other than hospital investors allowed?

What should a P.O. (non-physician) partner look like (for POEs)?

- Anyone
- No authority on day to day
- Non-medical, then expertise in area involved – skill of expertise
- Active in the field of practice
- Vested interest in healthcare of community

Who shouldn't be a partner?

- Publicly traded companies

<u>APPEND</u>

- As stated, CMS test (still to be decided on bullet one).

Bullet one: A physician practice that is owned, directly or indirectly, by one or more physicians or by a hospital; (still TBD)

From 10/29 and 10/30/07 notes on pages 6 & 7:

- Recommendation to clarify language on bullet 3 of diagnostic radiology office
- Recommendation to clarify bullet 4 of E&M
- Still TBD on bullet 1 (of IDTF) - ownership

Committee recommends adopting as stated in CMS test from notes pages 6 & 7 (as appended).

Committee noted that definitions don't match up with CMS.

Physician's Office Exemption (doctor involved must have):

- Financial interest
- Majority ownership
- Skin in the game ("actively practicing" physician
- Could be hospital or others

Why should hospitals be the only entity allowed to partner with physicians offices? At what point is it about community and what point is it about profit?

NOTES FROM CON SESSION 2: *November 14, 2007*

MORNING

Committee Members Present November 14, 2007:

1. Victor Joseph
2. Bruce Jayne
3. Aaron Wolirich (for Wade Hinger)
4. Robert Bridges (Kim Black in pm)
5. Cathy Giessel (Jeremy Hayes in pm)
6. Michael Zielaskiewicz
7. Gerald Nicholson
8. Shawn Morrow
9. Mike Powers
10. Jason Paret
11. Creed Marnikunian
12. Brad Cruz
13. Jeff Kinion
14. Chakri
15. Joel Gilbertson

*14 people voting during afternoon

CON Process

-Advisory Committee: Panel of impartial knowledgeable individuals (specific to issue at hand)

-Local knowledge to get true determination of need

RECOMMENDATIONS TO STATE:

Standards should be used as CON decision criteria, in a data driven process that takes community plans and market forces into account, with a letter requiring P.O.E. grantees to submit data to the state

CON Process:

Standards should be used as decision criteria

-Should be a data driven process

- A letter should be sent to CON P.O.E. grantees requiring them to submit data (# of patients served, etc.)

-Needs should be based on data, according to community (need community plans)

-Take market forces into consideration: can hospitals compete in the geographic area?

-Consider the capacity of each community

(grantees subject to revalidation based on data/numbers/need)

-Should the CON process specify a window of response for other (competing) CON applications?

Administrative Hearing Process Recommendations:

Needs to be more timely (90 days)

Who can contest decision? *Note: Lawsuits start after the state decision.*

To curb lawsuits

Recommend to state:

2) Provide clear definitions of the following:

- Physician offices,
- Define a small community? (Population) Population and capacity need to be looked at, in regard to the process.

3) Get and Provide accurate data
4) Make administrative process more timely
5) Create a consistent review process

Needed from the state prior to November 20, 2007 (the next CON committee meeting):

- Need data from state – go back 2 years and group appeals according to the nature of appeals. (need data by 11/20/07)

Enforcement Discussion took place and items were voted on regarding enforcement.

AFTERNOON DISCUSSION NOTES (11/14/07 PM):
(Discussion specific to definition of P.O.E. in CON process)

State needs to provide better data statistics according to geographical area.

Different definitions for smaller communities needed for the CON process.

Small	P.O.E.
100% physician owned	
Partner with local hospitals	
Partner with anyone in community (dividend)	

What is the definition of a small community? What about the Kenai Peninsula?

Would there be a different advisory committee for each specific situation? That would be too big of a burden on the state.

Large communities:
Anchorage, Mat-Su, Fairbanks: all others are small communities.

*Populations should be counted and need should be determined consistently (military/Native).

The population formula should be subject to revalidation if/when the population changes.

There are no hard deadlines in the CON process. Committee voted on deadline lengths, in days.

Committee asked, who can file an appeal? *Reference: Current regulations, pg. 17 at bottom of page (item #15). Must prove you are truly adversely affected party in order to file an appeal. If you don't prove you're adversely affected there may be a consequence. Committee decided that the burden is on the appellant.

Who has the authority to enforce? The Commissioner should have the authority.

Committee requests that the state clarify: Appellants should have to prove they're providing "similar" services (make less vague). Recommendation to state: clarify what is "similar"

*Small and large communities discussion was reintroduced.

Threshold Discussion

Comments from CON Committee members:

- -Facilities threshold should be increased (same for small and large communities).
- -Laws should be passed requiring physician's offices – or those practicing medicine have to serve all comers (all patients regardless of whether they have insurance or are able to pay).
- -Everyone seems to want to protect smaller communities and let larger communities have competition.
- -How does state determine need? Will the state count capacity of those outside CON when making CON capacity decisions? (this is recommended by the committee; as a way of collecting current data regarding the capacity of a community)
- -Smaller community hospitals don't have cath labs or oncology, etc. so need added protection from competition.

Facilities Threshold: Could make a recommendation to state to differentiate thresholds for large and small communities.

Equipment Thresholds:

Recommendation: state needs to clarify definition of equipment – differentiate between facility equipment and medical equipment (#2 on page 18) via an advisory group (see below):

Advisory group	Clearly define the differences between which items require CON • Refurbished equipment (no CON) • Novel scope of services (possible CON) • Replacement equipment a. Same purpose (no CON) b. New equipment (no CON)

Facilities Thresholds:

Recommendation: state needs to clarify definition of facilities

Advisory group	Clearly define the differences between which items require CON • Refurbished, remodeling existing facilities, renovating and/or repairing existing facilities for same use, same scope of services– no added services (no CON) • Novel scope of services (possible CON) • Replacement facilities a. Same purpose (no CON) b. New facilities (no CON)

Committee Members Present November 20, 2007:

1. Ward Hinger
2. Jeff Kinion
3. Robert Bridges
4. Chakri Inampudi
5. Lester Lewis (for Brad Cruz)
6. Shawn Morrow
7. James Shill
8. Paul Morris (for Ed Lamb)
9. Al Parrish
10. Mike Powers
11. Norman Stephens
12. Ryan Smith
13. Vicki Crumptoula (for Creed Markunian)
14. Baxter Burton
15. Gerald Nicholson
16. Jeremy Hayes
17. Bruce Jayne
18. Jim Jordan for (Ross Tanner)
19. Rod Betit
20. Victor Joseph
21. Jay Butler

Session 3 CON Committee Meeting Notes: November 20, 2007

HOPES

-Discuss 1 & 5: 1 is ASCs. 5 is POE recommendation to differentiate ownership requirements for large and small communities
-Would like hospitals to be able to partner with physicians
-Empower state to have some teeth in compliance

CONCERNS

-Discuss Enforcement
-Discuss Follow up
-Quality - measures

Decision Considerations:

Will it reduce litigation?
Will it assist in cost containment?
Will it assist in access?
Does it level the playing field?

MORNING DISCUSSION NOTES (11/20/07 am):

Victor Joseph asked to remove Tribal Exclusion language from the agenda.

Comments from Committee Members:

- Technical (knowledgeable and impartial) advisory group should be utilized regarding equipment.
- State needs to fund a data driven process in order to avoid a litigious CON environment. It takes resources to collect data.

Litigation Overview (Kevin Henderson, DHSS):

9 appeals last year; 3 related to POE and Imaging Services, 3 related to ASCs, 2 related to RPTCs(??).

ASCs (in CON process) Discussion - 8:00am

- ownership: active vs. passive investor
- scope of practice
- in practice together
- common EIN

Comments from Committee Members:

- Is it for own use or is it a pool of physician's who go to hospitals. Physicians differentiate by coding.
- Suggestion: 100% ownership

FOLLOW UP/ENFORCEMENT Discussion - 8:30am

Comments from Committee Members:

- Enforcement on bigger issues: keep it simple so as not to create more unfunded mandates.
- Penalty for gross misstatements or lack of compliance. State doesn't have resources to provide follow up for each CON grantee.
- No ASC definition in Statutes or Regulations.
- P.O.s should still have to submit a letter of determination to the state; the letters will provide data to the state which will help in determining need for CON applicants.
- There should be a mechanism that shows whether an MRI (etc.) is running at capacity.
- Count everything in a community when looking at need.
- capacity needs to be defined for this discussion. 600 CT scans for our office vs. 30,000 at Providence.
- Confidentiality of data submitted should be maintained.
- The group is not addressing purpose statement that was addressed on day one, so the group might as well throw out purpose statement.
- When we are talking about POE imaging modalities we will never come to a collective understanding.
- If there is a timely review and appeal process along with clear definitions, loopholes will be decreased.

POE Ownership for P.O. Exemption Discussion – 10am

Comments from Committee Members:

- Hospitals in large communities need to partner with imaging (for POE).
- If hospitals can partner with radiologists (radiology office exemption) there is a negative consequence that hospitals can play favorites.
- We voted before and decided that hospitals could partner and it was 83% yes, I'm surprised we're back discussing this issue again.
- Shows the need to split between large and small communities.
- How much competition can you put into a community without creating adverse affects?
- Concerned about a level playing field.
- I have shifted and have resigned to the fact that I'll have radiology centers.

- Physicians' don't have the ability to threaten hospitals as they are small entities. If we say yes to allow hospitals to practice in P.O.E. which was made for physicians. There shouldn't be a loophole for hospitals and/or large entities.
- From a legal standpoint, makes sense to make consistent ground rules. 100% for small communities then make it 100% for large communtieis. Make it the same across the board for ease of managing the process.
- Consistency to eliminate loopholes.
- Allowing abuse: number between 50% ownership. If forced to agree on a number, might find consensus. How easy is it to abuse? 50% is easy to abuse. Can we come up with a number to limit abuse?
- Process concerns: hope this is the last time the CON committee has to meet in the next 15 years. Drivers: Healthcare environment and an expectation of greater immigration between hospitals and primary care. Primary care is struggling and will probably go away eventually.
- See change in healthcare. In Maine 2/3 of new graduating medical students are employed by hospitals. Agree about the standards. There is a distinct difference between large and small communities. Small communities can be adversely affected. If there is going to be a CON process, should have to prove, through data, that you're (the state) doing what you set out to do (cost control, etc.). POE ownership: makes no difference in a large community.
- Every step we've said let's reduce competition. Hospitals need to embrace new competitors. CON reduced to competitive barriers to anything new in the state. Don't think there should be any restrictions. Don't see the difference between hospitals and any other businesses. Should be open to anyone.
- There is a need for some type of hospitals to work together. Geographic issue has come up.
- Either 100% physician owned or should be able to partner with anyone.
- 100% physician owned
- Level and consistent process
- Do see loopholes. All go through P.O.E. process.
- Level the playing field and create consistency in the P.O.E. application process. Everyone wants to level the playing field. Make the process crystal clear with rules for the Commissioner to follow. Have an issue with hospitals partnering with physicians. It's ok for physicians to partner with physicians.

Last vote on P.O.E. Exemption. Meeting adjourned at 3pm.

See attached excel spreadsheet

Position on House Bill 337 (Working Draft) - February 8, 2008
Prepared by: Rod Betit, President/CEO

ASHNHA Alaska State Hospital and Nursing Home Association

Madam Chairman, members of the Committee, I would like to speak to all three parts of the bill before you today, specifically the provisions repealing certain parts of CON law, creation of a Health Care Commission, and imposing mandatory information reporting requirements.

First, let me give a quick overview on ASHNHA's position on each section of HB337 followed by a sectional analysis.

ASHNHA's POSITION ON SECTIONS CONTAINED IN HB 337:

▪ Section 1 - Statewide Health Plan:	SUPPORT AS IS
▪ Section 2 - Repeal CON provisions	OPPOSE
▪ Section 3 - Repeal CON provisions	OPPOSE
▪ Section 4- Establish Alaska Health Care Commission	SUPPORT IF AMENDED
▪ Section 4- Establish Health Care Information Office & Establish Mandatory Reporting Requirement	SUPPORT IF AMENDED
▪ Section 5 - More Alaska Health Care Commission	SUPPORT AS IS
▪ Section 6 - More CON Repeal Provisions	OPPOSE
▪ Section 7 - More CON Repeal Provisions	OPPOSE
▪ Section 8 - CON Repeal Effective Dates	OPPOSE
▪ Section 9 - Statewide Health Plan Effective Date	SUPPORT AS IS
▪ Section 9 - Health Care Commission Effective Date	SUPPORT AS IS
▪ Section 9 - Health Care Information Office Effective Date	SUPPORT AS IS
▪ Section 9 - Mandatory Reporting Effective Date	OPPOSE

Section 1 - Statewide Health Plan:

ASHNHA supports the recommendation by the Governor's Health Care Strategies Planning Council to develop a statewide health plan. Development of a plan would serve several important purposes. One of those would be to plan for the appropriate development of health care infrastructure and equipment to meet Alaskan's health care needs both in the near and long term. Absence of such a plan has contributed to the ongoing disagreement as to both the quantity of unmet health needs in the State, and the most appropriate setting in which to meet those needs community by community. Initial development of a statewide health plan will likely take several years to complete but could be kept current and relevant with minimal effort and cost.

Amendments recommended in Statewide Health Plan Section 1:
(a) None. ASHNHA supports this section as written.

Position on House Bill 337 (Working Draft) - February 8, 2008
Prepared by: Rod Betit, President/CEO

Sections 2, 3, 6, 7, and 8 - Repeal Certificate of Need:

ASHNHA's membership opposes these sections of HB337. We do not believe repealing CON is good public health policy.

Alaska CON statutes were updated in 2004 to align CON review with rapidly evolving changes in health care delivery practices. These statutory changes have only recently been fully implemented (2006) after a lengthy regulatory adoption effort by the Department of Health & Social Services to fully define the criteria to be used for review of any CON application.

Yes differences of opinion continued to exist within the stakeholder community on how these new laws should be applied. To address this Commissioner Jackson appointed a committee of 21 individuals to meet face-to-face to iron out their differences in September 2007. As you already know, by an 89% vote the participants voted **not to repeal CON.**

As a member of the Rulemaking Committee I can report that we took this charge very seriously. I and other participants believe we did what was asked of us and produced a series of recommendations for improving CON policy and process that the Department should consider or ask us to go back and work on further.

ASHNHA members believe the repeal proposed by HB337 would invite uncontrolled growth of health care services. This would have serious consequences to the financial viability of existing health care providers and undermine their ability to provide needed medical services to their community. In addition we believe it will cause health care costs to increase more rapidly rather than less rapidly.

Decisions around CON should be made in concert with other strategies the State should consider to make the health care market a more balanced economic environment for hospitals. You have heard these arguments before so I will not repeat them here. I have attached the key arguments ASHNHA has made over the years as to why CON is an important health policy tool.

Recently you heard testimony from the Department of Justice about their opinion on whether CON process is helpful or not to the consumer. I have attached a policy paper from the American Health Planning Association that gives a critique of the Department of Justice paper for your additional consideration.

Amendments recommended in CON sections of bill (3, 4, 6, 7, 8, 9, 10):
(a) ASHNHA's members recommend that all CON sections be deleted from HB337 and the Department asked to continue working with the Rulemaking Committee to refine CON regulations and processes to resolve any continuing concerns.

ASHNHA Alaska State Hospital and Nursing Home Association

Section 4 - Establish Alaska Health Care Commission:

ASHNHA members support the creation of a Commission to develop incremental strategies to provide affordable, quality health care choices for all Alaskans, to oversee development of the State's health care data information base, and to promote individuals taking responsibility to improve their overall health status. While ASHNHA supports the establishment of a Commission, HB337 does not reflect the diverse membership needed to assure broad based support of Commission recommendations.

Amendments recommended in Health Care Commission Section 2:
(a) ASHNHA recommends the membership be modified to reduce the number of Administration representatives on the Commission, while increasing the number of consumers, business and health care industry representative on the Commission.
(b) Recommend balancing the member selection process in some way. Selection of the members should have support by the Governor and the Legislature.
There are several approaches to modifying the membership and appointment components of HB337 that would be acceptable to ASHNHA members, and we commit to meet immediately with the Administration, the Legislature and other interested parties to come up with a suitable solution to this important component of the bill.

Section 4 - Establish Information Office & Mandatory Reporting:

ASHNHA supports the goal of providing accurate and current health care information for consumers to assist them in making health care decisions. ASHNHA's members have been voluntarily expanding reporting of health care cost, quality and charity care information for many years. All of that information is already available to the Department.

Until now the State has shown no interest in creating a consumer friendly resource containing this type of health care information. Further there was no discussion with ASHNHA or other health care providers about how to best approach this goal prior to introduction of this legislation. This is a complicated and involved process that will take years to fully develop and implement. Some progress could be made by the State in the short term using the data already being provided by hospitals but certainly not by July 1, 2008.

While ASHNHA's members support the goal of expanding health care cost and quality information for consumers, there has been little thought given to how this will actually be accomplished. The bill is unclear on critical details with which to answer the following four questions:

1. **Who must report this data?** AS 47.32 (page 8, line 9) lists the following:
   - ambulatory surgical centers;
   - assisted living homes;
   - child care facilities;

- child placement agencies;
- foster homes;
- free-standing birth centers;
- home health agencies;
- hospices, or agencies providing hospice services
- hospitals;
- intermediate care facilities for the mentally retarded;
- maternity homes;
- nursing facilities;
- residential child care facilities;
- residential psychiatric treatment centers;
- rural health clinics;
- runaway shelters.
- Independent Diagnostic Testing Facilities come in on page 8, line 5

All of these entities would be expected to start reporting yet undefined data effective July 1, 2008. This is clearly not possible. Noticeably missing from the list is a key piece of the cost and quality equation for consumers, that of the physician. How can a consumer make a choice about their care without this information?

Also missing from this list is pharmacies yet the Department presented a State of Florida web site as an example of what the consumer would be able to access under their reporting program. How could that come about without statutory authority?

ASHNHA questions if all of these other 'facilities' understand whether they are to report under the provisions of HB337 effective July 1, 2008.

2. What data must be reported and how does that compare to what is reported now?
It is not clear what data the department is looking for. ASHNHA is the only entity in the list of impacted facilities that currently reports data and we do that voluntarily. The list of reports available to the Department right now is quite extensive including:

- ASHNHA members report all hospital inpatient data related to patient stays. This includes diagnosis, all treatment provided, charges, reimbursement received, third party insurers, length of stay, sex of patient, age of patient, patient residence, and a host of other information.
- ASHNHA members voluntary expanded beyond the inpatient data base to the department this year by reporting data for all outpatient services provided and all emergency department services. This includes all outpatient surgery, lab and imaging services
- ASHNHA members report financial data on the operations of their facilities on an annual basis.
- ASHNHA members report data on key quality measures to the federal Department of Health & Human Services and to the American Hospital

Association. These data are available to the public at these posted web sites for comparing Alaska hospitals to each other as well as comparing Alaska hospitals to those in other states.

- Many ASHNHA members also voluntarily report quality information on a number of quality and patient safety measures that go beyond that reported to the federal government. This data is also publicly available.
- ASHNHA members have supported the Legislature's desire to add health care facility acquired infections to the list of reportable items as proposed in SB 68 that passed out of this committee last year. We believe this is important information to report but recognize it is a difficult area to be statistically reliable in. SB 68 creates a process over several years to look at what other states have done, design a reporting program suitable for Alaska, and then implement reporting in Alaska. It is wise to go slow here as 14 states have passed similar legislation but only 2 or 3 have actually begun reporting due to the challenges this reporting presents.
- For the first time ASHNHA's members have again voluntarily launched and funded a new report that will give you and all Alaskans a look at the total 'community benefits' Alaska's hospitals provide. I have attached a copy of this inaugural report. Please note our first effort at collecting this information accumulated $150 million in benefits of one type or other. This number will grow in future years as we become more sophisticated at capturing this information.

3. How will the data be collected, validated and kept current?

There are several ways to develop and implement a reporting system. Three of those would be as follows for the hospital portion of this system. Which path is the State on?

- Hospitals could send the same raw data we send to these other expert data agencies and the department could edit, purge confidential information, format and post the data to their own data web site. This would be Herculean task essentially replicating efforts and costs already being invested; or
- The department could enter into an agreement with little or no cost to obtain the data from all the data agencies already producing reports and populate their own data site with that clean data. The department could then use that data to generate the online consumer inquiry system being envisioned; or
- The department site could provide links to these already existing data sites for ease of consumer movement through the system. This would be the simplest, least costly, and easiest to maintain approach because the cost, liability and administrative burden to keep the data current and accurate rest with other expert data parties.

4. When can reporting of new data elements realistically begin?

Clearly, answers to the above questions need to be obtained to evaluate when any new mandatory reporting requirement can be realistically implemented. In ASHNHA's

opinion the July 1, 2008 date is simply unrealistic. Further when you consider all the other providers who will be expected to report that do not have the jump start that hospitals have by voluntarily reporting for many years, there is serious question about how thoroughly the scope and complexity of this proposal has been fleshed out.

Amendments recommended in mandatory health care data reporting Section 2:
(a) Recommend these provisions be rewritten in a permissive rather than prescriptive tone and the development/implementation responsibility be placed with the Health Care Commission.
(b) Recommend all parties who will be expected to report be clearly listed in this section of the bill. The parties listed should include pharmacies and physicians which are not now included.
(c) Recommend the timelines for implementation of reporting be extended beyond July 1, 2008. There simply is no way this timeline can be met.
(d) Recommend the department initiate its reporting efforts as it pertains to hospitals with the data already being provided that is not now being made available to consumers after a dialog with ASHNHA on how to best proceed.

Thank you for the opportunity to testify and express ASHNHA's members' opinions about this legislation.

The Federal Trade Commission
&
Certificate of Need Regulation

An AHPA Critique

January 2005

American Health Planning Association

. . . putting it all together

I. Overview

In July 2004, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) issued a joint report titled *Improving Health Care: A Dose of Competition.* Described as advisory in nature, ostensibly, it offers recommendations on how to "improve the balance between competition and regulation in health care."[1] The authors say they want "to inform consumers, businesses, *[and]* policy-makers on a range of issues affecting the cost, quality, and accessibility of health care."[2] Except for more effective enforcement of antitrust laws, which falls within the scope of the agencies' responsibilities, the report seeks to effect change by influencing the views and conduct of others, particularly national and State policymakers.

Eliminating certificate of need (CON) regulation is only one of several problematic arguments and recommendations presented. It is the only recommendation that has gained much public attention, but the issue is given only cursory, dismissive consideration in the report.[3] The overall thrust of the report is to encourage movement to a "consumer driven" health care system that relies on market forces to determine costs (prices), access, and quality. CON regulation and planning is seen as an obvious obstacle to this goal, but the report also cautions against:

- Over-reliance on health insurance;
- The system-distorting effects of Medicare and other "administered pricing" schemes;
- Economic cross-subsidies within the system;
- Government-imposed service mandates;
- Attempting to control prescription drug prices;
- Permitting collective bargains by physicians, and generally; and
- Any other action or process contemplated, in the pursuit of other (perhaps larger) social goals and interests that might limit competition or the full application of market forces.

Criticism of CON regulation in *Improving Health Care* is not surprising. Given the FTC *raison d'etre* of promoting free markets and unfettered competition, and its longstanding opposition to CON programs, little else could be expected. Nevertheless, the unsupported conclusion that CON programs "pose anticompetitive risks" and "risk entrenching oligopolists and eroding consumer welfare" is little more than doctrinaire posturing. Similarly, the recommendation that States with CON programs "reconsider whether these programs best serve their citizens' health care needs" is gratuitous. State legislatures do this regularly, often annually.

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[1] FTC-DOJ press release July 23, 2004, at <http://www.ftc.gov/opa/2004/07/heathcarerpt.htm>.

[2] *Ibid.*

[3] CON and related planning are treated briefly as "miscellaneous subjects" in Chapter 8, the last chapter of the report. Although there are occasional allusions to CON regulation elsewhere in the report, the question is discussed directly in fewer than 10 pages of the 350 plus page report. The cursory treatment of CON planning and regulation appears calculated: CON regulation is treated dismissively, almost as an afterthought, in the body of the report, but is elevated to prominence in the recommendations (number 2) offered "to improve competition in health care markets". ***Improving Health Care: A Dose of Competition.*** A Report by the Federal Trade Commission and the Department of Justice, July 2004. The full report is available at www.ftc.gov. See specifically Chapter 8 (pp. 1-6) and the Executive Summary (p.22), both of which discuss CON regulation directly.

opposed CON regulation in Georgia[7], Hawaii[8], Maryland[9], Michigan[10], Nebraska[11], New York[12], North Carolina[13], Ohio[14], Pennsylvania[15], and Virginia.[16]

FTC attacks have been multifaceted, with arguments ranging from the purported failure of CON regulation to meet legislative cost control objectives to assertions that it results in higher operating costs and charges, threatens quality, reduces innovation and system efficiency, and

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[7] In March 1988, FTC staff said "We believe the continued existence of CON regulation is contrary to the interests of health care consumers in Georgia. . . . More importantly, CON regulation tends to foster higher prices, lower quality and reduced innovation in health care markets". See FTC press release, March 7, 1988, at www.ftc.gov.

[8] In early1987, FTC staff told Hawaii legislators "we strongly encourage repeal of CON legislation. There is no evidence that the CON regulatory process has served its intended purpose of controlling health care costs. Indeed, CON regulation may well increase prices to consumers by restricting supply of hospital services below the level that would exist in a non regulated competitive environment." See FTC press release, March 17, 1987, at www.ftc.gov.

[9] In 1987, FTC staff advised Maryland policymakers to not control ambulatory surgery center development under the State's CON program. See FTC Annual Report, 1987, U. S. Federal Trade Commission, Washington, D.C. at www.ftc.gov.

[10] In March 1988, FTC staff advised Michigan health officials that the State's CON regulations were (are) "contrary to the interests of health care consumers in Michigan" because they "tend to decrease efficiency and impede competition." The staff also asserted "any potential benefits of CON regulation are likely to be outweighed by its adverse effects on competition in health care markets." See FTC press release, May 9, 1988, at www.ftc.gov.

[11] In February 1989, FTC staff informed the Nebraska Legislature "continuing CON regulation is likely to harm consumers by increasing the price and decreasing the quality of health services." See FTC press release, February 24, 1989, at www.ftc.gov

[12] In February 1987, FTC staff advised New York City Health Systems Agency officials that a contemplated reduction in excess hospital capacity "would substantially reduce the incentives for hospitals in New York City to improve the price and quality of their services." Consequently, officials should "rely on the hospitals themselves, rather than government regulation, to determine appropriate capacity levels." See FTC press release, February 10, 1987, at www.ftc.gov.

[13] In March 1989, FTC staff told the North Carolina policy-makers "CON regulation does not appear to be an efficient way to ensure the quality of health care services, to assure that health care is available to the indigent, or to control Medicaid expenditures for nursing home beds." Staff also argued "consumers would most likely be better served if CON regulations were removed." See FTC press release, March 14, 1989, at www.ftc.gov.

[14] In June 1989, FTC staff told the Ohio State Senate "'there is near universal agreement' among health care economists that Certificate of Need regulation 'has been unsuccessful in containing health care costs.'" See FTC press release June 22, 1989, at www.ftc.gov.

[15] In April 1988, FTC staff urged Pennsylvania to eliminate CON regulation, arguing "the benefits of CON regulation, if any, are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, continuing CON regulation is likely to harm consumers by increasing the price and decreasing the quality of health services in the state." See FTC press release, April 1, 1988, at www.ftc.gov

[16] In August 1987, FTC staff advised Virginia officials to eliminate its CON regulation of health care facilities because such regulation is "contrary to the interests of health care consumers" and "market forces generally allocate society's resources far better than decisions of government planners." FTC staff also asserted "any potential benefits of CON regulation are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, CON regulation is likely to harm consumers on balance by increasing the price, and decreasing the quality, of health services in Virginia." See FTC press release, August 10, 1987, at www.ftc.gov.

An underlying objective of the report is to change views on this question, especially among policymakers. The authors' recognize that mediating forces (insurance, public health and payer programs, lack of accurate and reliable cost and quality information, and the absence of a truly independent and sovereign consumer) make the current health care market an imperfect one. They insist that, given this circumstance, all efforts should be directed at perfecting the market, and paying directly any additional cost that a free unfettered market may entail.

FTC arguments presented in opposition to CON regulation, and in support of unrestrained market forces, are necessarily largely doctrinaire. There is little analytical or factual basis for the criticism of CON or for the recommendation to eliminate it. Similarly, other than recitation of orthodox economic doctrine, little is presented to demonstrate that market forces have had, or are likely to have, the positive effects in the health care system that the authors claim or assume.

The FTC opposes most barriers to market entry, whatever their nature, purpose or function, as an article of faith. The report makes clear that the FTC opposition is grounded in orthodox economic doctrine and the principles of the "American" market system. The Executive Summary of the report concludes with the report anthem:

> "The fundamental premise of the American free-market system is that consumer welfare is maximized by open competition and consumer sovereignty – even when complex products and services such as health care are involved. . . . The Agencies do not have a pre-existing preference for any particular model for the financing and delivery of health care. Such matters are best left to the impersonal workings of the marketplace." ***Improving Health Care: A Dose of Competition,*** *Executive Summary,* p. 11.

In other words, the FTC is not in favor of a particular model as long as the *de facto* model is the "American free market" model. Doctrine, or perhaps faith and hope, trump experience and reason. This is not surprising, given the FTC's mission of promoting competition. This inherent bias, though understandable, does not absolve the Commission of its responsibility to avoid substituting belief for fact, or to refrain from accepting uncorroborated allegations of interested parties as fact. The report, and the record compiled in producing it, shows the Commission relied on belief and uncorroborated allegations rather than demonstrated fact in its rebuke of CON.

Although packaged and presented as a major new report, the evidence and argument against CON regulation is either a rehash of FTC arguments from the 1980s,[19] or the uncorroborated self-serving allegations of interested parties.[20] There is a notable absence of documented fact or cogent analysis. No new evidence is offered to support the claim that, by raising market entry barriers for some services, CON raises costs, impedes access, or threatens quality. References to

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[19] See Keith B. Anderson and David I. Kass, ***Certificate of Need Regulation of Entry into Home Health Care***, FTC staff report, January 1986; Monica Noether, ***Competition Among Hospitals***, FTC staff report, May 1987; and Daniel Sherman, ***The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis***, FTC staff report, January 1988.

[20] See unsupported and anecdotal testimony of John Hennessy, Executive Director, Kansas City Cancer Centers (a subsidiary of U. S. Oncology) and Megan Price, Director, Contracts and Communications, Professional Nurses Association. Both were (are) disappointed CON applicants who made bold, uncorroborated assertions that are problematic on their face.

effects of CON regulation. Statements to the contrary notwithstanding, these are doctrinaire assertions, not demonstrated fact.

IV. Allusive Arguments

The FTC assertion that, rather than helping control costs, "there is considerable evidence" that CON "can actually drive up prices by fostering anticompetitive barrier to entry" is not supported by credible evidence. This uncorroborated assertion is typical of the argument presented. No source for this conclusion is cited. The language, like the argument itself, is in the subjunctive, opaque and indirect. Considerable evidence is not otherwise defined or identified. So-called "anticompetitive barriers," such as CON, are not clearly distinguished from barriers such as licensure and insurance payment rules and regulations that, though they limit or otherwise affect market entry as forcefully as CON regulation, presumably do not rise to the level of being an "anticompetitive barrier".

The opaque assertion that CON "can actually drive up prices" permits the writers to project their views without having to meet the burden of proving them. Orthodox economic theory holds that market entry barriers "can," and often do result in higher prices in many markets, but there is no credible evidence that CON has, or necessarily does, lead to higher costs in health care. Recourse to theory is necessary if the argument is to appear plausible. In other words, if there is not evidence to document the practice or effect, simply assert repeatedly the belief or theory.

V. Related Opinions and Findings

The attack on CON, though sharp, is a small part of *Improving Health Care*. Perhaps more problematic are the related assumptions, beliefs and recommendations that, if implemented, would undermine community and regional planning, and subject those in need of health services to the vagaries of unfettered market forces. These views and assumptions include:

- *Opposition to Internal Subsidies (Cross-subsidies)*. The report recommends that governments (federal and state) re-examine their support of policies and practices that underlie cross-subsidies in health care markets. The rationale offered for this recommendation is that internal (service-to-service) subsidies are inefficient and have the "potential to distort competition."

  The report is indifferent to the implications of the loss of service to those who now benefit from these subsidies, noting that "competition cannot provide resources to those who lack them; it does not work well when certain facilities are expected to use higher profits in certain areas to cross-subsidize uncompensated care." If there is a genuine commitment to assist those benefiting from cross-subsidization, the necessity of such assistance should be weighed and, if found meritorious, be provided directly to recipients (presumably through direct payment or vouchers) because that approach would be "more efficient" and "transparent". There is no discussion of the practicality of this approach or of the likely affects on current beneficiaries of subsidies. The net social and health system gain (benefit) of eliminating cross-subsidization is assumed to be positive.

- *Health Insurance Distorts Markets and Competition*. The report does not recommend specific changes in the Medicare program or in other health insurer coverage or payment practices, but asserts repeatedly that insurance coverage and payment

theory, some level of surplus capacity—the level to be determined by market forces—is necessary for a competitive system. FTC staff assumes that the market will punish, and ultimately root out, surplus capacity, inappropriately low occupancy levels, and inefficiency (e.g., low throughput). In other words, there cannot be too many hospitals, hospital beds, or too much service capacity of any kind in a free market.[27]

VI. Supportable Report Findings and Recommendations

- *Information Asymmetry*. The report recognizes that a major imperfection in the current system is the lack of accurate and reliable cost and quality information consumers can use in seeking health services. The recommendation for a concerted, system-wide effort to make more of such information available is commendable. Unfortunately, the report does not recognize or acknowledge that knowledge and information asymmetry is inherent (unavoidable), nor does it suggest ways to deal with this question.

- *Enhance Incentives to Lower Costs and Improve Quality*. The recommendations offered in the report are generic in nature and unobjectionable. The need to improve incentives to reduce or control costs, and to improve quality is recognized and accepted by nearly everyone. Unfortunately, little guidance is offered about the specific questions to be addressed, the means to address them, or the problems likely to be encountered in dealing with them.

- *Implement Institute of Medicine Licensure Reforms.* The suggestion that the membership, and consumer representation on state health facility and service licensing boards be broadened is laudable. Both the scope and substance of licensing decisions, and the processes used in making them, need reform.

VII. Problematic Report Findings and Recommendations

- *Eliminate CON Regulation*. The recommendation that CON programs be eliminated is based largely on doctrine. The argument is a repackaged version of decades-old FTC arguments and positions. No new studies or analyses are offered. Empirical evidence and recent studies and experience showing the benefits of CON regulation are largely dismissed, not disproved.

- *Re-examine Subsidies in Health Care Services*. The value of all health care polices and practices should be examined periodically as a matter of course. In fact, most are. The underlying FTC argument against cross-subsidization is based on orthodox economic doctrine, not on an assessment of their intrinsic merit or the rationale for them. Most subsidies are in place for notably laudable purposes. Some, perhaps all, may need to be reconsidered, but not for theoretical or doctrinal reasons. The evolved connection between cross-subsidization, provision of charity care, and CON review contingencies and conditions is of considerable social value. Current practices should not be changed unless meaningful alternatives are in place.

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[27] Jeffrey Zuckerman, Director, Bureau of Competition, U. S. Federal Trade Commission, to Giri Vuppala, Assistant Director, Planning and Implementation, Health Systems Agency of New York City, February 9, 1987.

positive aspects of planning, CON regulation, facility licensure, and a number of other mediating social constraints are in place, in part, because market forces do not, and probably cannot, be used to discipline this market.

- *The studies critical of CON cited by the FTC are not reliable*. The argument that planning and CON regulation result in higher costs and prices, inferior quality, reduced access, less innovation, and lower operating efficiency, though asserted repeatedly, is not supported by demonstrated fact. This refrain is based largely on an unwavering adherence to orthodox economic doctrine.

  Most of the sources cited that purportedly show negative economic and quality effects of CON regulation, are FTC staff reports and FTC staff statements, which in turn, are often based on these studies. Thus, many of the citations are self-referential. The base studies themselves are suspect. The data used, the timeframes covered, and analytical processes relied upon are problematic. The conclusions drawn are debatable. Based on multivariate regression analysis and statistical correlation, none of these "studies" demonstrates cause and effect and, beyond theoretical conjecture, none explains the method or mechanism by which the changes observed were achieved.

  Analyses that try to examine the economic and quality effects of CON regulation yield mixed findings, not the uniformly negative results asserted in the FTC report. Contrary to the impression conveyed in the FTC report, there are no reliable studies showing the effects of CON regulation on access to care, system efficiency, innovation, or other specific system characteristics.

- *Empirical evidence and experience are ignored or treated dismissively*. The recently reported experience of U.S. automakers showing lower costs in States with CON programs, and published analyses showing significantly lower mortality rates among open-heart surgery patients in States with CON programs, are dismissed. This information, when acknowledged, is usually cited in the testimony of a commentator or hearing panel member and dismissed by pairing it with opposing anecdotal testimony of CON critics.

- *Health care as a privilege*. The FTC prides itself on working in the interest of the consumer, the average citizen. It argues that "consumer driven" health care system is desirable and possible if market forces are permitted free reign. The paean to consumer control, though superficially attractive, borders on the disingenuous when examined in the light of economic and health system realities. The report prescribes theoretical cures to real problems. The discussion is at the macroeconomic level. The assumption appears to be that, if you address, at least theoretically, overarching system questions and imperfections, maximum benefit will flow (trickle down) to the individual.

  Unfortunately, the individual is treated as a theoretical economic entity or construct. Market realities are such that, under FTC prescriptions access, to quality health care would become a privilege, not a right or reasonable social expectation, dependent upon the economic standing, the knowledge base, and the social status of the individual. The report appears to anticipate and endorse this outcome. It speaks approvingly of consumers needing incentives to "balance costs and benefits and search for lower cost health care with the

outcome is well known. It has been documented repeatedly for many of the services regulated under CON programs. CON regulation is the most reliable and practicable tool for implementing service, institutional and regional planning policies and practices that facilitate and ensure appropriately high program volumes.

X. Conclusions

Improving Health Care: A Dose of Competition appears to be largely a political treatise. It is not an analytical study. The underlying purpose appears to be an attempt to frame (shape) the debate over the nature and evolutionary direction of the U.S. health care system. It touts a "consumer driven" system as the ultimate goal. The report argues that this is possible if the nation has the courage to forgo internal subsidies, service mandates, over-reliance on insurance and government financing and purchasing, government regulation, and associated practices. Reliance on unrestrained market forces is prescribed as the best approach to determining health care capacity, cost, quality, and access. The negative effects of unfettered competition are not examined.

In terms of health planning and CON regulation, the report repackages and restates decades-old arguments against regulation. No new data, information or analysis is offered, and empirical evidence indicative of the efficacy of CON regulation and associated planning is dismissed. By almost any measure, the presentation is largely doctrinaire, based on an unwavering belief in the applicability of orthodox economic doctrine in health care rather than an objective analysis of market realities and experience.

The stated FTC goals of market efficiency, consumer control and informed stakeholders have been integral to community-based health planning for more than 40 years. The community has always been, and remains, an integral part of the planning, development and regulatory processes. The principal difference between FTC beliefs and assumptions, and those favoring planning and targeted regulation is how best to manage the tension between public and private interests, and between short-term and long-term perspectives and incentives. AHPA has always believed in the importance of community-oriented health care services and systems, and encourages ongoing reassessment of health planning and CON regulation to ensure they remain responsive to technological change, evolving health care practices, and community values and needs. The Association will continue to support these principles and practices.

ASHNHA
Alaska State Hospital and Nursing Home Association

REASONS FOR CONTINUING CERTIFICATE OF NEED IN ALASKA

- **Health care is not a conventional market; its economic forces are different.**
  - Health care has a finite need in each community. Introduction of additional medical providers redistributes finite revenue among more providers with 'winners and losers' in the community. Community hospitals will be the 'losers' as profitable services are aggressively sought by new imaging, surgery and specialty hospital providers. This will have profound adverse impact on their ability to fully meet community expectations.
  - Hospitals and nursing homes must offer a full range of outpatient, inpatient and emergency services 24 hours a day, 7 days a week, 365 days a year. A number of these essential services do not produce adequate revenue to offset their cost of operation yet they must be offered to fully meet the needs of the community.
  - Health care is heavily regulated by federal & state laws. These regulations do not afford the health care provider the same flexibility and efficiency found in other markets. For example, a reduction in profitable service lines cannot be recovered by increased pricing as nearly one-half of hospital revenue comes from sources that set their own pricing (Medicare and Medicaid).
  - There is no assurance that introducing additional health care providers in a community will reduce cost to the consumer. In fact there is recent research that continues to suggest otherwise.
- **Hospitals must serve all persons in the community that need care regardless of ability to pay and are the key responder in community disaster response.**
  - Without CON, specialty providers can enter the market and create unfair competition by offering only the most profitable medical services and limiting the number of non-paying and underinsured patients that they will see.
  - 18 of Alaska's 25 hospitals are 'sole community providers' which risk financial instability and irreparable harm to community residents if the State does not insure that there is need for more health care infrastructure before it is introduced into the community.
  - Hospitals invest preparedness funds and extensive training to serve the community in event of natural disasters, pandemic flu, biological, and chemical threats. These expenses are not recovered from health care purchasers and only partially offset by federal/state grants. CON helps assure these important services will not be threatened by loss of critical revenue to keep these protections in place.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM January 29, 2008

SUBJECT: Explanation of CSHB 337(HES) (Work Order No. 25-GH2050\C)

TO: Representative Peggy Wilson
Attn: Becky Rooney

FROM: Jean M. Mischel
Legislative Counsel

Enclosed is the draft CS you requested for HB 337. I wanted to alert you that the change requested to the definition of "health care facility" in the draft CS at page 8 is confusing. Paragraphs (C) and (D) were added to that definition but refer to a "provider" rather than a type of facility. In addition, those paragraphs contain substantive law requiring those providers to be "certified under regulations adopted by the department." Since that requirement appears nowhere else in statute, as a legal matter, those providers do not exist.

In addition, you asked two questions in your request for this CS.

1. Does removing the phrase "ex officio nonvoting" from the appointment of legislative members of the proposed Alaska Health Care Commission make the appointment illegal? Since the commission is established within an executive branch department, having legislative members vote on matters before the commission may violate the separation of powers doctrine. On the other hand, the commission's primary function appears to be advisory under new section 18.09.010(1) so that a decision making role does not appear to interfere with the independent functions of the executive and legislative branches of government. The only other function of the commission appears to be administrative in that the commission "approves" information for posting on the website and again does not appear to affect the separate providers of the legislative or executive branch.

2. Are health care regions already defined in statute? I have found only one reference to a "health care region" and that is in the context of regional public assistance programs under AS 47.27.300. That section does not define "region." On the other hand, local health units are defined as follows:

> **Sec. 18.10.010. Local health unit and health board.** Each community or settlement outside an incorporated city is a health unit. In each health unit there shall be a board of health composed of the president of the school board and two citizens of the unit selected by the school

> board. At least one of the members of the health board must, where practicable, be a licensed physician. In a health unit where there is no school board, the commissioner shall appoint three residents of the unit to the local board of health, at least one member of which must, where practicable, be a licensed physician.

In addition, health districts are described under AS 18.10.040 as:

> **Sec. 18.10.040. Health districts.** Two or more contiguous health units of two or more local boards of health for contiguous incorporated cities may be constituted a health district by the department. Members of the board of health for this type of health district shall be appointed by the department from residents of each health unit or incorporated city represented in the health district in the numbers and for the periods of time determined by the department.

If I may be of further assistance, please advise.

JMM:med
08-056.med

Enclosure

Amend CON

Wade Hoek

From: Governor Sarah Palin [governor@gov.state.ak.us]
Sent: Tuesday, February 20, 2007 2:30 PM
To: nkoumal@rcpcfairbanks.org
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Sunday, February 18, 2007 1:16 PM
To: governor@gov.state.ak.us
Subject: Health_Care

Web mail from: Ms. Nancy Koumal
address: PO Box 82779 FAIRBANKS AK 99708

MESSAGE:
Dear Governor Palin, I'm writing to express my thoughts on CON, and my interest in the health-care
system study task that you are setting-up. The current CON policy that shut down the Open Imaging Center in Fairbanks is wrong. They not only were a great business but I know from recent personal experience I saved more than $500 on a MRI using them instead of FMH. FMH has a monopoly and it isn't fair. Having said that, I have a great interest in the health-care system in Alaska and US,and would like to offer my service on the new task force being formed. As a 24 yr resident of Fairbanks,a RN for 25yrs,14 yrs at FMH, and most recently at the Resource Center for Parents and Children WIC Program for almost 6yrs, I feel somewhat qualified to have an opinion on many issues affecting our health-care policies and the well-being of our citizens, most notably our children. Please consider my opinion and my offer. Sincerly, Nancy Koumal RN

nkoumal@rcpcfairbanks.org

Michelle Fabrello

From: Linda Manns [linda_manns@gov.state.ak.us]
Sent: Wednesday, February 28, 2007 3:05 PM
To: Michelle Fabrello
Subject: Message to the Governor

Attachments: Linda_Manns.vcf

1857
AK

Linda_Manns.vcf
(348 B)

Fairbanks constituent call 2-28-07 3pm

To: Governor Palin
From: David & Ardena Morway
2120 Badger Rd.
North Pole, Ak. 99705
488-9089

Message:
We support SB65 and HB 4.
To amend the certificate of need. The people of Fairbanks and North Pole deserve to have more then one treatment option.

Thank you.

XRN CON File

Office of the Governor
550 West 7th Ave, Ste 1700
Anchorage, AK 99501
(907-269-7450)

2220
AK

PUBLIC OPINION MESSAGE

Date: *March 14, 2007*

From: *David Newton*
1045 Beech Lane #18
Anchorage, AK 99501-6015

To: *Governor Palin*

Subject: *Two bills*

Operator: *Tara Fradley*

I am supporting two bills, HB4 and SB65. If these get passed to you please sign them. HB4 is sponsored by Bob Lynn and SB65 is sponsored by Charlie Huggins.

Supports Repeal CON

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Thursday, February 07, 2008 10:20 AM
To: westie@ptialaska.net
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Thursday, February 07, 2008 6:28 AM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Web mail from: Jan Ponder
address: PO Box 56992 North Pole AK 99705

MESSAGE:
Good Morning,
As a single parent, I attemp to "stretch" monthly income. I would like to see a new option in Fairbanks for health care. I am not a supporter of the certicate of need. In these times of high oil prices and struggling, it is difficult to make ends meet. The doctors seem to be getting back to the humanity reason of being a doctor. Lets allow better health care and hopefully the cost of care will come down.

westie@ptialaska.net

Support Repeal CON file

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Wednesday, February 06, 2008 8:57 AM
To: loisk@starband.net
Subject: RE: Certificate of Need

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: loisk@starband.net [mailto:loisk@starband.net]
Sent: Tuesday, February 05, 2008 3:04 PM
To: Governor Sarah Palin (GOV sponsored)
Cc: Bunde, Con (LAA); Cowdery, John (LAA); Davis, Bettye J (LAA); Dyson, Fred (LAA); Ellis, Johnny (LAA); Elton, Kim S (LAA); French, Hollis (LAA); Green, Lyda N (LAA); Hoffman, Lyman F (LAA); Huggins, Charlie (LAA); Kookesh, Albert (LAA); McGuire, Lesil L (LAA); Senator_Donald_Olson@legis.state.ak.us; Stedman, Bert K (LAA); Stevens, Gary L (LAA); Therriault, Gene (LAA); Thomas, Joe (LAA); Senator_Thomas_Wagoner@legis.state.ak.us; Wielechowski, Bill (LAA); Wilken, Gary R (LAA); Buch, Bob (LAA); Chenault, Mike (LAA); Cissna, Sharon (LAA); Coghill, John (LAA); Representative_Harry_Crawfod@legis.state.ak.us; Representative_Nancy-Dahlstrom@legis.state.ak.us; Doll, Andrea (LAA); Doogan, Mike (LAA); Edgmon, Bryce E (LAA); Fairclough, Anna (LAA); Foster, Neal (LAA); Gara, Les (LAA); Gardner, Berta (LAA); Gatto, Carl (LAA); Gruenberg, Max F (LAA); Representative_David_Gruenberg%legis.state.ak.us.Representative_John_Harris@legis.state.ak.us; Hawker, Mike (LAA); Holmes, Lindsey (LAA); Representative_Lyle_Johansen@legis.state.ak.us; Johnson, Craig W (LAA); Joule, Reggie (LAA); Kawasaki, Scott Jw (LAA); Keller, Wes (LAA); Representative_Michael_Kelly@legis.state.ak.us; Kerttula, Beth (LAA); Ledoux, Gabrielle R (LAA); Lynn, Bob (LAA); Meyer, Kevin G (LAA); Nelson, Mary (LAA); Neuman, Mark A (LAA); Olson, Kurt E (LAA); Ramras, Jay B (LAA); Roses, Bob (LAA); Salmon, Woodie W (LAA); Samuels, Ralph (LAA); Seaton, Paul (LAA); Stoltze, Bill (LAA); Representative_William_Thomas@starband.net; "Jr."@legis.state.ak.us; Wilson, Peggy A (LAA)
Subject: RE: Certificate of Need

PLEASE - PLEASE - GET RID OF THE MONOPOLY IN FAIRBANKS/NORTHPOLE/SALCHA AREAS! RE: Fairbanks Memorial Hospital/Banner Health Care

We have had our own experiences regarding 'treatment' in the ER - from either not looking close enough at circumstances/symptoms and 'diagnosis,'
more so in the last year, specifically 6 mos.

People are not getting what is needed or misdiagnosed or not checked thoroughly enough, and given wrong RX's, etc., for condition.

If you want 'specifics' contact me, glad to fill you in.

It is bad enough to at last resort have to go to the ER, they do not like to see you back in there with same symptoms on your next visit, let alone again, within 'hours,' and speaking from experience, and after nearly 4 hrs. in ER, placed in ICU for 3 days, second visit in less than 5 hrs.

Ed and Lois Kincaid
7921 Steese Hwy.
Fairbanks, AK 99712-1744
[redacted]-389-2324
[redacted]sk@starband.net

Supports repeal of CON

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Wednesday, January 30, 2008 7:46 AM
To: cpurdy@northstar.k12.ak.us
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Tuesday, January 29, 2008 2:37 PM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Web mail from: Ms. Carolyn Purdy
address: P.O. Box 16255 Two Rivers AK 99716

MESSAGE:
Thank for trying to get rid of the certificate of need!

I read the notes from the commission. Most of the people involved seemed to be those who would lose money if they lose their stranglehold on the system. I've been a nurse in Alaska since 1971. I have seen the "good old boy club" with the hospital in Fairbanks chase away lots of medical providers. Then they put the same service in place with what appears to me to inferior service. Since they won't allow the competition we will never know for sure. There is a cancer center in Seattle donated by a Fairbanks man because he couldn't put it here or get the treatment he needed. The new Providence cancer center was rumored to be here. The imaging center that accepted 300 lb people is gone and now those people have to go to somewhere else. There was a cardiac clinic, and eye clinic that I know of that have gone elsewhere.

Why does Kelly (part of the hospital) have a say so on this bill? Its a conflict of interest for him.

I tried to contact LIO and website comes back to error message so thought I would try sending this through you.

cpurdy@northstar.k12.ak.us

Supports Repeal

Office of the Governor
PO Box 110001
Juneau, AK 99811-0001
3rd Floor Capitol Building
(907-465-3500)

PUBLIC OPINION MESSAGE

Date: 2/14/2008

From: Ms. Tess N. Bonney
1824 Kennedy Street
Fairbanks, AK 99709
907.590.9976

To: Governor Palin

Subject: Please repeal certificate of need.

Operator: Donna Collins

cc:

Supports Repeal CON

Office of the Governor
PO Box 110001
Juneau, AK 99811-0001
3rd Floor Capitol Building
(907-465-3500)

PUBLIC OPINION MESSAGE

Date: 12-12-07

From: Ruth Vzey 451-3299

To: Governor Palin

Subject: Certificate of Need and Fluride in water

Message: Against the Certificate of Need, also pls take the Fluride out

Operator: sb

Supports Repeal

Governor Palin
House Bill - 337
Senate Bill - 245
Fax: 907-465-3532

Date: 2/14/08

RE: Elimination of the Certificate of Need (CON)

Yes, I support your initiative to eliminate the Certificated of Need (CON) in Alaska.

As a concerned citizen of Alaska I have the right to the best health care I can receive.

I have the right to know my treatment options, including alternative treatment and to obtain a second opinion.

I have the right to know the quality and cost of my doctor, hospital, medical devices, drugs or procedures before I make the decision for treatment.

I have the right to be part of the lowest-cost, highest quality care I can receive.

I feel I have lost these rights due to the restriction of trade the Certificate of Need has imposed on the health care in Alaska.

I support your initiative to eliminate the Certificate of Need (CON) in our state of Alaska.

Print Name: Carol Nordin
Signature: Carol Nordin
Address: 1243 Grenac Rd Fairbanks, AK 99709
Telephone: 907 479-3476

Fax Received
FEB 14 2008
Office of the Governor

repeal CON

NRN
Con File

2196
AK

Fax Received
MAR 14 2007

Jayne Hempstead DVM
P.O. Box 175
Cantwell, AK 99729
907-768-2228
March 14, 2007

Dear Senator Charlie Huggins, Representative Bob Lynn and Governor Sarah Palin;

This letter is regarding the Certificate of Need mandate and the closure of Alaska Open Imaging Center in Fairbanks. Last year I was referred to Alaska Open Imaging Center in Fairbanks for an MRI. The service was excellent and because I live 150 miles out of town, they were able to perform the procedure the same day I was referred by my physician. I would consider it a huge loss should Alaska Open Imaging Center be forced to permanently close their doors. Even though the CON mandate seemed like a good idea at the time in 1974, it certainly is forcing out any competition. When we inquired about a surgical procedure at Fairbanks Memorial Hospital, we were treated, frankly rather rudely and decided to drive to Anchorage for the procedure. The decision was made not only because of the "curt" interactions over the phone but it was also less expensive in Anchorage. My husband and I would like to support the Fairbanks community but if Fairbanks Memorial Hospital is the only provider of surgical and imaging services we will be forced to take our business to Anchorage.

We need new legislation to eliminate CON in Alaska. Thank you for your attention to this matter.

Jayne Hempstead

OFFICE OF
HA
JUN 7

950 Windflower Lane
Fairbanks, Alaska 99712
June 8, 2007

NIR

Sarah H. Palin, Governor
State of Alaska
P. O. Box 110001
Juneau, Alaska 99811

3505
AK

SUBJECT: Certificate of Need (CON) Controversy

Dear Governor Palin,

First off, please accept my apologies for the weather Fairbanks provided for your recent picnic. It was unfortunate for you and your husband to host those of us who had the desire to share with you and provide our appreciation for your courage and strong State support. Thank You.

I am writing with a specific request. The populace of interior Alaska would benefit if you would appoint a member of your staff to look into the CON events of the last eighteen (18) months. During this period, members of the Department of Health and Social Services, the Judicial Department, members of the Legislature and local Fairbanks entities have been intimately involved. I have no personal fiscal interest or benefit in any outcomes surrounding the present controversy. However, I am a 32-year Alaska resident, a PERS and TRS retiree, have a family background of providing enhanced medical service, and truly believe in the right of free enterprise.

Fairbanks Memorial Hospital (FMH), now an affiliate of Banner Health Systems, has long been a fiscal and political entity preventing individual physicians from developing outpatient surgical facilities in the Fairbanks area. Alaska State Representative Kelly, a member of the FMH Board of Directors, has, I believe unethically, written a most demeaning letter to many Fairbanks residents criticizing those physicians who might wish to build private facilities. The CON issue is not isolated to the present, but has been a problem for as long as I can recall. Currently there is CON legislation bottled in committee as the chairperson will not bring it up for discussion, for reasons I believe are politically motivated. Regardless of my personal beliefs, the concept needs discussion, honest review, and resolution in a manner which is determined only with the people needing service in mind.

I am aware there are many broader concerns on your desk, many which directly relate to all the people of Alaska. However, the CON issue has been with us for many years and requires resolution based on facts and not on biased information.

Respectfully,

Boy N. Collier, PhD

repeal CON

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Tuesday, August 07, 2007 2:06 PM
To: eval@mosquitonet.com
Subject: RE: Legal_and_lawsuits

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Tuesday, August 07, 2007 12:29 PM
To: Governor Sarah Palin (GOV sponsored)
Subject: Legal_and_lawsuits

Web mail from: Ms. Eva Anderson
address: P.O. Box 60014 Fairbanks AK 99706
907-479-6428

MESSAGE:
this is a copy of letter sent to Kurt West, Office of the Commissioner, regarding the review of the CON laws.rnrncc: Governor Sarah Palin;rnrnDear Mr. West,rnrnWe greatly urge you to consider the needs of the people of Fairbanks as your committee reviews and hopefully listens to our wishes concerning the repeal of the CON laws.rnrnOur family (40+ members) has been in Fairbanks since 1941 aand on many occasions have found it necessary to travel to the lower 48 or to Anchorage for our medical needs with no other available choice.rnrnAs you are aware Fairbanks has one hospital and no outpatient surgical facilities, while Anchorage has three hospitals and five outpatient surgical facilities.rnrnOnce again we urge you to consider the needs of the people and to repeal the CON laws and allow a free market system in Fairbanks and all of Alaska.rnrnSincerely,rnrnTury G. and Eva L. Anderson

eval@mosquitonet.com

Supports File N/R

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Wednesday, January 16, 2008 8:13 AM
To: ersausdahl@hotmail.com
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Tuesday, January 15, 2008 9:53 PM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Web mail from: Ms. Elizabeth Stinson
address: 14830 Goldenview Drive Anchorage AK 99516
907 227 5919

MESSAGE:
Dear Governor Palin,

I want to thank you for your stand on the CON issue. Your State of the State of address was wonderful with a theme of taking Alaska back for Alaskans. Repeal of the CON law will be a major step in that regard. We need to expand health care options, reduce costs, and attract new quality physcians to the state. Repeal of the CON will go along way towards making that happen. Your care and concern for the state was evident throughout the whole speech. I like the way you inspired all of us toward unity and common goals. It left me feeling excited, full of hope for the future of our great state, and proud to be an Alaskan.

Sincerely,
Elizabeth Stinson

ersausdahl@hotmail.com

Supports File N/R

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Wednesday, January 16, 2008 8:20 AM
To: alaskatrail@mtaonline.net
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Tuesday, January 15, 2008 6:49 PM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Web mail from: Cheryl Ward
address: PO Box 13 Willow AK 99688

MESSAGE:
/EEEES ! Delete the monopoly of the corrupt certificate of need for healthcare providers to open up competition to BRING DOWN COST ! I have worked in the health care field for almost 40 years and do not have any health insurance due to unavailable thru my employer. Try SHOPPING for private pay healthcare ! Nobody does it, but it will open your eyes to UNBELIEVABLE STICKER SHOCK when pricing proceedures when paying out of pocket!!! PLEASE help ! ! Open up competition! Eliminate bribes & lobbying by Mega Healthcare owners who DO on our Alaska hospitals and healthcare!!! Thank you!

alaskatrail@mtaonline.net

File
CON

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Wednesday, January 16, 2008 1:46 PM
To: Savland, Monica L (GOV)
Subject: FW: State of the State Address
Attachments: CON PUBLIC INFORMATION.doc; Health Care in Alaska.doc

From: Dr. Stephen Sutley [mailto:ssutley@aksurgerycenter.com]
Sent: Wednesday, January 16, 2008 1:18 PM
To: Palin, Sarah H (GOV)
Cc: drsutley@aksurgerycenter.com
Subject: State of the State Address

Dear Governor Palin,

Thank you!!!

First, I would like to thank your for attending our open house at the Steese Medical Center.

Next I would like to compliment you on your "state of the state" address yesterday. The address was great and I appreciate your vision and leadership for Alaska.

I especially want to thank for your stand on the elimination of the CON. This, I believe, took real courage, leadership and vision for the future Alaska's medical care.

I will do what ever I can to get public support and comments of support to our legislators.

For your information I am enclosing two separate white papers we have been working on to educate the public and gain support for the elimination of the CON. We will be distributing these in our respective patient waiting areas.

Thanks again for your vision, courage, support and leadership.

Dr. Stephen H. Sutley

Certificate of Need (CON):

What is a Certificate of Need? **January 1, 2008**

- **The Certificate of Need (CON) concept was introduced by congress in 1974 under the National Health Act to control the cost of health care.**

Why was a Certificate of Need legislation originally passed?

- **The primary goal of CON was to control health care costs.**
- **Congress mandated that each state pass their CON laws.**

Why was the Certificate of Need repealed by the US Congress?

- **In 1986 Congress repealed the 1974 Health Care Act and its requirement for state CON laws because the CON process failed miserably to control the cost of health care.**
- **In essence, the CON protects the preexisting facilities from competition by restricting new facilities from the marketplace.**
- **In other words, the CON creates monopolies for large hospital organizations much like the Standard oil monopoly that the Supreme Court broke up in 1911.**

The majority of the States have repealed or modified the CON laws.

- **Fourteen states have repealed all their CON regulations, while most of the other states have significantly downsized theirs.**

What has the State of Alaska done with its CON regulations?

- **The state of Alaska has gone the opposite direction.**
- **Under the lobbying powers of the major hospitals (FMH / Banner Health, Providence), and self-serving politicians the CON laws have become more restrictive and controlling.**

Why was the Certificate of Need not repealed in Alaska?

- **Protection for the hospitals.**

Why do Banner Health / Fairbanks Memorial Hospital spend thousands of dollars in advertising?

- **To maintain their monopoly by keeping competition out.**
- **If indeed FMH was public oriented and as cost effective as they profess, they would not need to advertise.**

Results:

- **The free market system has been eliminated from the health care industry in Alaska.**

The Hospitals Flawed Argument:

The hospitals arguments for maintaining Certificate of Need (CON) and corresponding rebuttals:

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: June 1998.*.

- 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.

In 1972, the United States Congress passed a law requiring all states to implement a Certificated of Need program in an attempt to control health care costs and prevent duplicating of services throughout the country. In 1986, the Congress repealed the CON requirements after it became clear this law was unsuccessful in controlling health care costs.

In June 2004, the Federal Trade Commission and the Department of Justice jointly released a study stating the CON program was not successful in containing healthcare spending or hospital costs and can actually increase prices by fostering anticompetitive barriers. Their recommendation was for the states with CON programs to reconsider whether these programs best serve their citizens' healthcare needs.

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?
- Not only is Fairbanks Memorial Hospital provided with government subsides for indigent care the doctors who actually provide the care for these indigent patients are not provided any subsides or compensation for their services.

Repealing the Certificate of Need laws in Alaska would lead to the development of Ambulatory Surgery Centers 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 Ambulatory Surgery Centers in this country, the number of Hospital closures declined. Numerous other factors however, have been cited for hospital closures including:

- Hospital mergers and acquisitions leading to large scale market consolidation during the 1990's
- Failure to adjust to managed care and large reductions in average length of stay
- 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.

The Alaska State Legislature
W3.legis.state.ak.us/

This web site offers you the ability to locate and contact your legislator(s), track the progress of bills, access committee information and stay up-to-date on legislative activities.

We encourage you to contact your legislator(s) and support legislation to eliminate the Alaska Certificate of Need (CON) law.

Please share this information to friends, family and associates.

Health Care in Alaska

Patient Rights: **January 1, 2008**

- You have the right to know your treatment options, including alternative treatment and to obtain a second opinion.
- You have the right to know the quality and cost of your doctor, hospital, medical device, drug or procedure before you make a decision.
- You have the right to be part of the lowest-cost, highest quality care you can receive.
- **Did you know you are rapidly losing these rights?**

Information:

Alaska is the most restrictive and controlling state in the nation when it comes to health care. Such restriction and control is even more evident right here in Fairbanks. Fairbanks Memorial Hospital is the only hospital and is protected from competition by an archaic state regulation called the certificate of need (CON) law. With the recent purchase of Tanana Valley Clinic (TVC), the largest privately owned clinic in Fairbanks, Fairbanks Memorial Hospital will have a total monopoly on health care in Fairbanks.

City Comparison:	Population	Hospitals	Ambulatory Out Patient Surgery Centers
Fairbanks North Star Borough:	86,754	1	0
North Pole City	1,828	0	0
Anchorage Municipality:	278,700	3	5
Wasilla:	9,236	1	2

Fairbanks Memorial Community Hospital:
Hospital Foundation:

- Net worth 330 million includes real estate, holdings and investments.
- Tax exempt

Banner Health Corporation: (based in Arizona).

- Net worth: multibillion dollars
- Hospital Foundation contracted Banner Health to manage Fairbanks Memorial Hospital.
- Where does this money go?
    - Arizona, not Alaska

Health Care in Alaska

Mr. Van Allen, president of Timeline Recruiting, a physician recruitment firm based in Columbia, MO. states "Shortage of physicians is a real health care crisis." Printed on Sunday, January 13, 2008, Fairbanks Daily News-Miner, Opinion section. Mr. Allen states "The U.S. health care industry is already seriously understaffed, and the lack of physicians is felt most acutely in rural and poor urban areas where a dearth of money and state-of-the-art equipment serve as a disincentive for attracting new talent."

Mr. Allen states the real problem of the ailing health care system is physician supply and patient demand. This predicament facing American health care system will only be exacerbated with universal health care. Here in America, one only needs to look at the Veterans Administration for a glimpse of what the health care system might be like. The deplorable conditions at Walter Reed Army Medical Center made headlines in February 2007, in the Washington Post where Dana Priest and Anne Hull wrote of the deterioration of a facility that stands just five miles from the White House and Congress.

The imbalanced supply and demand in the universal health care industry in Canada has resulted in a robust semi-underground market for quality health care for the wealthy Canadians who are increasingly turning to "cash-and-carry" services with doctors who have removed themselves from the compulsory insurance system. This has resulted in poorer Canadians being left out in the cold. It is well documented that many Canadians wait an inordinate amount of time for their much needed medical and surgical care. Many Canadians end up coming to the United States for their treatment.

To compound the shortage of physicians in America is the fact that more and more doctors are leaving the profession because of increasing difficulty work environment, rising cost of liability insurance, the constant threat of being sued and increasing administrative burdens. **Alaska, specifically Fairbanks has another reason for the alarming rate of losing physicians. The reason being the state sponsored restriction of trade. This restriction of trade is the Certificate of Need (CON) law.**

With all of this in mind what are the odds that Alaska can recruit physicians in rural areas if we can not even retain the physician we have. With the current loss of physicians, the aging population of our physicians and the inability to recruit physicians Alaska (specifically, Fairbanks) is already in a health care crisis.

Health Care reform is one of the biggest political issues in America and will be a major issue in the upcoming 2008 elections. Over the last few decades we have seen many examples of political and corporate corruption throughout our nation and in Alaska. Many of our political and corporate leaders are disdainful of our national values and the interests of the people they claim to serve. These lofty political and corporate elites have abandoned American values and its people. These elitists have, unfortunately, been elevated to positions of tremendous social, economic and political powers. This elitist attitude and abuse of power along with the apathy and tolerance of the American citizens have allowed this assault on the welfare of our citizens and the future of this country.

The political elites talk of reforming our national health care system which, in many cases, is nothing more than socialized medicine controlled by the medical corporations and third-party payers (medical insurance). Government controlled universal health care is **not** the answer. What good is universal health care if there are not enough physicians to satisfy patient demands? These political elites seem to put no emphasizes on training more physicians or retaining the physicians already in practice. These politicians do not talk about preventive medicine, early detection, and wellness, individual responsibilities, nor do they address the biggest reasons for the our out of control health care costs: third-party payers (medical insurance) and the medical insurance system (malpractice insurance), or tort reform to protect good doctors from predatory lawsuits.

The Certificate of Need was the governments attempt to control the cost of health care. It failed, it had the opposite effect. The United States Congress repealed the CON requirements and encouraged the states to do the same. Some states saw the wisdom in removing the CON requirements others did not. Fourteen states have repealed all their CON regulations; most of the other states have significantly downsized their CON regulations. Alaska, however, was one of the only states that decided to maintain the entire CON requirements even though it was shown in multiple studies that it failed to control or reduce the cost of medical care.

The CON is nothing more than a restriction of trade, in other words a monopoly. This restriction of trade will ultimately dictate to you how, where and when you will receive health care. The certificate of need is but one example of the political and corporate elite's attitude in determining what is best for Alaska citizens.

What is a monopoly?
Monopoly: exclusive control or ownership, as of a commodity or service.
(Webster Dictionary)

The Unites States Government has a history of breaking up monopolies dating back to Theodore Roosevelt's administration when the Supreme Court recognized the anticompetitive activity of the Standard Oil business activity and broke this company monopoly up in 1911. Yet, even after the United States Congress repealed the CON requirements because of its failure to control health care costs; Alaskan politicians continue to support this big business monopoly and restriction of trade.

It is extremely important to understand that the health care system in America is second to none. Regardless of your political persuasion, government or multi-billion dollar corporations in control of our health care is not the answer. This as already been demonstrated with the Veterans Administration system, Walter Reed Army Center and the Certificate of Need program. Four hundred years of entrepreneurial, technology, and science-based free market capitalism in America has proven citizens get more choices, higher quality, and reduced prices.

Supports Repeal

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Monday, August 27, 2007 9:55 AM
To: ckwenzel@ak.net
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Saturday, August 25, 2007 9:12 AM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Web mail from: Mr. Christopher Wenzel
address: 125 Wire St. #A Juneau AK 99801
(907)523-0424

MESSAGE:
Gov Palin, rnrnWant to start by letting you know you are doing a good job. rnI would like to touch on the subject of health care in this state and the rest of the country. rnrnFirst of all, I would like to see an end to the Certificates of Need. We all lose in the end due to the loss of competition. I understand that a small town with a small hospital cannot have another hospital come in to compete with the local folks but that is not going to happen anyway. A CON is not needed these days. Competition will not come in unless it is needed period. Case in point, in Fairbanks, we lost an MRI/CT because the hospital did not want competition. The people lost.... not the company. In Anchorage, a dialysis unit is needed due to a waiting list. No one other than the existing will come in there due to the CON. That part of health care needs competition badly due to large companies eating up smaller ones..... the largest being from Germany. rnrnNext, the nursing short!
age. The big health care companies, including our dialysis company, are starting to open schools in other countries to train nurses and then signing contracts with them to work in the US. What is going on here. Why aren't they doing that here. (Labor is cheaper there and the bet is that people won't raise a stink when their nurse can't speak English because they have the only dialysis unit in town.rnI have an idea. Let's make Alaska the nursing education magnet and oasis of the country. We can ask for money from healthcare in the lower 48 to train nurses and we will reap the benefits of the nurses coming up here to get their degrees. This includes the schools, staff, and students spending money throughout the state. Many will stay put upon graduation. This could be a private/public venture. (I'll help start it). Being a nurse I am appalled at our sending money overseas to train nurses. So many of my co-workers would like to go to nursing school but they are eit!
her full or they cannot afford it. "Alaska, Nursing Ed!
ucation Capital of the US". Why not. rnrnThanks for listening, rnrnChris Wenzel RNrnDialysis Nurse

ckwenzel@ak.net

Kim, Anna C (GOV)

From: Kim, Anna C (GOV)
Sent: Monday, August 27, 2007 3:17 PM
To: 'ckwenzel@ak.net'
Subject: Certificate of Need

Dear Mr. Wenzel,

Thank you for writing Governor Palin with your thoughts on the Certificate of Need (CON) issue. She has asked that I respond on her behalf.

The CON issue has many complicating factors, and at one point, I shared your view. However, many other factors contribute to policy surrounding the CON program and the administration is actively working on a solution. The solution will take the cooperation of the administration as well as the legislature and stakeholders.

In addition to the many experts and public comment on this subject, the Governor's Health Care Planning Strategies Council will be taking a look at this issue as well.

Thanks again for taking the time to write.

Anna

Anna Kim
Special Staff Assistant
Office of the Governor

File

Supports CON Repeal

Kurt West
Office of the Commissioner
P. O. Box 110601
Juneau, AK 99811-0601

Re: Medical Certificate of Need in Fairbanks

Dear Commissioner West:

I am in favor of competition in the health care industry.

Since I turned 60 years old I just fell apart. I have had two knee replacements (one in Anchorage and one in Seattle), a detached retina repaired (in Anchorage), and two spine surgeries (one in California and one in Florida). This all occurred in the last six years. It would have been so much better to have had some of these surgeries closer to home.

Years ago (before I fell apart), I had cataract surgery at Pacific Cataract and Laser Institute (PCLI). I was really impressed that the doctor had his own surgery room with his own instruments, placed in the same place before each surgery, and the same assistants.. It seemed so organized and clean. I work at a desk and I am much more efficient working at my own desk rather than at some other desk.

Outpatient surgery centers are the future in medical care. The experience of having a procedure in an outpatient center is very different than having the same procedure in the hospital. It feels more efficient, more personal, up-to-date, and cleaner. Maybe that isn't fact, but it definitely feels that way.

I would love for you to ask the administration at Fairbanks Memorial Hospital why they are not receptive to new doctors coming to Fairbanks and using the hospital. Right now we do not have a urologist and have to go to Anchorage to see one. I have been told that Dr. Tomera, a urologist, would like to have privileges at Fairbanks Memorial. Also, years ago, Dr. Stinson wanted to open a practice here (a pain clinic) and could not get privileges at FMH. At that time the hospital had a very out-of-date pain clinic. I know, I had an epidural there that was awful. If the administration at the hospital really cared about the community, wouldn't they want us to have access to doctors that we choose? Are they are protecting the patients or themselves? Please ask them.

Sincerely,

Suzanne Maestas
366 Slater Street
Fairbanks, AK 99701

(907) 456-6931 (907) 474-4885

Support repeal

Kim, Anna C (GOV)

From: Kim, Anna C (GOV)
Sent: Tuesday, July 03, 2007 1:07 PM
To: daniel.cogan.ctr@clear.af.mil
Cc: Kim, Anna C (GOV)
Subject: CON
Attachments: Kim, Anna C (GOV).vcf

Dear Mr. Cogan,

Thank you for taking time to write Governor Palin with your concerns regarding the Certificate of Need program. She has asked that I respond to you.

The Governor campaigned on a philosophy of support for more competition in health care services, and yes as easy as it seems to just toss CON out as you say, the Certificate of Need issue is very complex, and generally, a change to one part of the health care system will have an impact on other parts. Moving forward with consideration is imperative.

The State of Alaska takes an interest in the expenditure of public and private capital for health care facilities and services to further three public policy objectives:

1) maintain access to health care
2) assure high quality health care, and
3) contain health care costs.

The certificate of need, for several years, has been one tool of several the state uses to achieve these goals. The CON program is intended to promote responsible health facility and service development and to contain health care costs. Proposed projects are evaluated, using regulatory standards, to determine whether or not sufficient need exists in a community to support the addition of new health care facilities or services.

The Health Care Strategies Planning Council will consider this issue, among many other health care issues related to access, cost and quality of care, and a report by the Council is due to the Governor on Jan. 1, 2008. More information about the council can be found at: http://www.hss.state.ak.us/hspc/

Thanks you for your input and interest.

Anna

Anna Kim
Special Staff Assistant

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Tuesday, July 03, 2007 10:29 AM
To: daniel.cogan.ctr@clear.af.mil
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMa '@gov.state.ak.us]
Sent: Monday, July 02, 2007 4:01 PM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Web mail from: Daniel Cogan
address: 6049 Cogan Drive Fairbanks AK 99712
(907)978-2652

MESSAGE:
Dear Governor Palin,

I was wondering if there is any push to toss the Certificate of Need out of the State. If there in no move, I think there should be. There is no reason for Clinics to have a strangle- hold on the ammount of medicine available to the public.

Sincerely,
Daniel Cogan

daniel.cogan.ctr@clear.af.mil
PLEASE ADD TO E-NEWS

Doesn't Support Repeal

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Tuesday, January 22, 2008 10:47 AM
To: ttn@acsalaska.net
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Saturday, January 19, 2008 8:02 PM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Web mail from: Ms. Terri Nettles
address: 46290 Roosevelt Circle Soldotna AK 99669
907-262-9115

MESSAGE:
I am deeply disappointed that you have chosen to end the CON. I voted for you and encouraged others to do the same. I felt that you would make our state and communities better. I am sorry to say that what I have seen up to this point is very concerning and I do not believe I could support you if the election were to be held today. I want a governor who listens to the people. Karlene Jackson appointed a committee to look at the CON issue and they proposed keeping it at this time and to look at modifying it to protect healthcare in the smaller communities in the state. You have completely ignored the recommendation of this committee. I work in a hospital and I am afraid that at the rate we are going our state healthcare will be a complete mess by the time your term in office is up and thousands of Alaskans will suffer. I feel some responsibility for this as I helped to elect you. I don't feel very positive about supporting you. I wish I could say I am proud of what you are doing, but unfortunately I don't feel you are representing the people of Alaska, but your own agenda and that does not make for a good leader. I apologize if you feel I have been unfair to you in my assessment of your leadership and the CON issue. I would love to hear your side of why you would turn a deaf ear to those who supported you and voted for you to become Alaska's first woman governor. The healthcare in my own community will be negatively affected if you are allowed to remove the CON program. I have been an Alaskan for over 40 years and I chose to raise my family here. I love Alaska and I have never really been one to voice my opinion on an issue; however, this issue is too important. In my experience the issues that I have struggled with in the past have been shared by many of my friends, family members, and co-workers. I do hope you will take some time to reconsider your position and look for ways to support healthcare in Alaska instead of the healthcare vultures who just want to move into a community to scrape the bo!
nes clean of the local hospital and physicians that have been committed to providing quality healthcare to the people living in the smaller communities.

ttn@acsalaska.net

Kim, Anna C (GOV)

From: Kim, Anna C (GOV)
Sent: Tuesday, January 22, 2008 5:34 PM
To: 'ttn@acsalaska.net'
Subject: CON

Dear Ms. Nettles,

Thank you for writing Governor Palin concerning the Governor's Alaska Health Care Transparency Act. She has asked that I respond on her behalf.

The CON committee was appointed to bring forth recommendations to the Governor for consideration. The Governor could either adopt the recommendations or choose to go her own direction. The legislation is the direction that Governor would like to go and has support among members in the legislative body as well as providers in the communities.

If you would like to remain involved in this process, please see BASIS for scheduling and hearing days/times at:
http://www.legis.state.ak.us/basis/get_bill.asp?bill=SB%20245&session=25
http://www.legis.state.ak.us/basis/get_bill.asp?session=25&bill=HB337

The bills have both been referred to House HESS and Senate HESS committees and then next to House and Senate Finance committees. The bill is scheduled to be heard in House HESS Jan 24th at 3:00 pm and Senate HESS Jan 25th at 1:30 pm.

Thank you for sharing your views on this legislation.

Anna

Anna Clark Kim
Special Staff Assistant
Office of the Governor

Supports repeal

Anna Kim

From: Anna Kim [anna_kim@gov.state.ak.us]
Sent: Tuesday, April 03, 2007 3:29 PM
To: montanakidhammer@yahoo.com
Cc: anna_kim@gov.state.ak.us
Subject: CON

Dear Mr. Wetherington,

Thank you for writing Governor Palin regarding the Certificate of Need issue.

Contacting your legislators is a great start. In addition, as the Health Care Planning Strategies Council rolls out soon, they will also be involved in making recommendations regarding CON. There are many opinions out there, however, the Governor still believes in competition and access to affordable health care for Alaskans.

Thanks you for your support.

Anna

Anna Kim, Special Staff Assistant
Office of the Governor

Anna Kim

From: Governor Sarah Palin [governor@gov.state.ak.us]
Sent: Tuesday, April 03, 2007 2:23 PM
To: montanakidhammer@yahoo.com
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Monday, April 02, 2007 6:39 PM
To: governor@gov.state.ak.us
Subject: Health_Care

Web mail from: Mr. Neil \'Kid\' Wetherington
address: P.O. Box 73291 Fairbanks AK 99707

MESSAGE:
Dear Governor Palin,

As per the Certificate of Need issue, I have contacted my Legislative members (Thomas and Kelly).
Senator Thomas hasn't contacted me. Mr. Kelly has a conflict of interest, gave me "his" opinion, telling me i need to have it his way. My memory service me Mike works of me, I DO NOT work for him. I've voiced my opinion, again, to him and received no reply. I am unable to re-elect him in District 7 in the future.

How can we help you, help the legislature support you, to help us (the cycle of reciprocity)? You and your cabinet are doing us proud, you are a true fiscal conservative, thank you.

Sincerely Submitted,

Neil Wetherington, The Montana Kid Hammer

montanakidhammer@yahoo.com

Want

Anna Kim

and CON

From: Anna Kim [anna_kim@gov.state.ak.us]
Sent: Thursday, March 29, 2007 2:55 PM
To: 'verena.hawkes@us.army.mil'
Subject: CON-AK Open Imaging Center

Dear Ms. Hawkes,

Thank you for writing Governor Palin with your concerns regarding the Certificate of Need requirements, specifically related to Alaska Open Imaging Center in Fairbanks.

The Governor is also concerned about this issue and is working toward a review of the regulations surrounding the Certificate of Need program in order to resolve the issue, but may take time. Please be assured that it is not being ignored.

Anna Kim, Special Staff Assistant
Office of the Governor

Anna Kim

From: Governor Sarah Palin [governor@gov.state.ak.us]
Sent: Thursday, March 29, 2007 2:23 PM
To: verena.hawkes@us.army.mil
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Tuesday, March 27, 2007 1:16 PM
To: governor@gov.state.ak.us
Subject: Health_Care

Web mail from: Ms. Verena Hawkes
address: 1820 Kittiwake Drive Fairbanks AK 99709

MESSAGE:
Dear Governor Palin,

Please consider amending the Certificate of Need for the Alaska Open Imaging Center Fairbanks Clinic. I have used the clinic and was very impressed with the staff's friendly and caring attitude. I was treated with respect and dignity and my experience was definitely a positive one.

I went to the Fairbanks Center to get a second opinion. I had previously had an MRI done at another local facility for pain in my shoulder, and nothing showed up. But my problem didn't go away, my arm continued to hurt and was weak, so after several months I asked for a second MRI. It was suggested that I try the recently opened Alaska Open Imaging Center Fairbanks Clinic because it had a newer, larger magnet which should give a clearer picture. And sure enough, it did. What was previously missed due to a poor MRI picture was immediately visible on the MRI that was done at the Alaska Open Imaging Center Fairbanks Clinic. I subsequently underwent surgery for a torn rotator cuff, completed my physical therapy and am now working on strengthening my shoulder and a complete recovery is expected.

I shudder to think of what I would be going through if the Alaska Open Imaging Center Fairbanks Clinic had not been available. I would still have constant pain and limited use of my shoulder. And this is exactly why Fairbanks needs competition in the health care arena. Without it, there is no incentive for the existing health care providers to improve the quality of their service, hours, customer service, equipment, or facilities.

Governor Palin, please help allow health care competition in Fairbanks! Amend the Certificate of Need requirements and let the people of Fairbanks have a choice in their health care needs. Please help reopen the Alaska Open Imaging Center Fairbanks Clinic!

Thank you for your concern regarding this critical issue.

VERENA HAWKES
Concerned Citizen

verena.hawkes@us.army.mil

Amd Con

VALLEY CHIROPRACTIC CLINIC, Inc.

Dr. James D. Martin
Chiropractic Physician

'Family Health Care Naturally'

APR 23 2007

April 12, 2007

1754
AK

closed 4/25/07

Governor Sarah Palin
P.O. Box 110001
Juneau, AK 99801-0001

Dear Governor Palin:

The current situation regarding Certificate of Need and its effect on availability of independent imaging services such as MRI, Ultrasound, and CT scans outside of a hospital setting is a concern to me and others in my profession. As a health care provider it is imperative that varied avenues of diagnostic studies be readily available to my patients at an affordable price. Many times treatment is held off while objective findings are confirmed by securing an MRI or CT scan. Limited facilities result in decreased availability, diminished quality of service, and often become cost prohibitive to the patient.

Healthcare costs continue to rise in Alaska while a large number of our citizens are without health care coverage and many more are under insured. Alaska is a state that promotes growth and commerce while protecting our environment and maintaining personal freedom for its citizens. Yet, Alaska's Certificate of Need regulations are some of the most stringent in the nation. Many major hospitals in Alaska are using the Certificate of Need to monopolize healthcare availability and therefore dictating the cost of such services beyond feasibility for many of our citizens.

I believe competition is good for Alaska. Competition in healthcare promotes availability of services and raises quality of service to the people of Alaska as providers compete for patient loyalty. We need to amend the Certificate of Need in Alaska raising the limits to ensure a better future in healthcare for our citizens.

Sincerely,

James D. Martin, D.C., CCSP
Alaska Delegate American Chiropractic Association

400 N. Main - Wasilla, Alaska 99654 - (907) 373-2022 Fax (907) 373-2029

Con File repeal

response attached

Wade Hoek

From: Governor Sarah Palin [governor@gov.state.ak.us]
Sent: Friday, March 16, 2007 3:59 PM
To: grhyneer@pobox.mtaonline.net
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Thursday, March 15, 2007 4:04 PM
To: governor@gov.state.ak.us
Subject: Health_Care

Web mail from: Mr. george rhyneer Jr. M.D.
address: 3260 Providence Dr. Ste 200 anchorage AK 99508

MESSAGE:
Dear Gov. Palin,

The quality of healthcare is actually dropping in Alaska due to the fact that patients are required tc go to certain hospitals and facilities due to backroom deals with insurance carriers. Having facilities compete and more of them will easily show this. People need to have choices. Many of the hospitals
already have monopolies and the CON law reinforces there ability to maintain the status quo. Excuses
made about the loss of private insured patients are just that. They don't want to see thier monopoly disappear. The people of Alaska are getting the short end of the stick. We, the physicians actually at the bedside see this daily. No hospital administrator... and I repeat this... no hospital administrator is working at night, at the bedside, in the operating rooms, in the imaging centers, with the nurses and physicians see this. They are big business...even when they say they are non profit. They are NOT long term forever alaskans. They will work here for 3-7 yea!
rs then move up the cooporate ladder.

My fellow physicians are Alaskans like you and here to stay. Get rid of that CON law!

sincerely and with respect. george rhyneer jr. orthopedic surgeon

grhyneer@pobox.mtaonline.net

Anna Kim

From: Anna Kim [anna_kim@gov.state.ak.us]
Sent: Saturday, March 17, 2007 1:20 PM
To: 'grhyneer@pobox.mtaonline.net'
Subject: CON Law

Dear Dr. Rhyneer,

Thank you for writing Governor Palin regarding the Certificate of Need law. She has asked that I respond to you directly.

Currently the department is evaluating these two legislative proposals. The Certificate of Need issue is very complex, and generally, a change to one part of the health care system will have an impact on other parts.

The State of Alaska takes an interest in the expenditure of public and private capital for health care facilities and services to further 3 public policy objectives: to 1) maintain access to health care, 1) assure high quality health care, and 3) contain health care costs.

As you may know, the Governor campaigned on a philosophy of support for more competition in health care services. As such, the official position of the administration is to support these bills as a way of bringing forth a discussion on how to best provide for more competition while maintaining these three policy objectives.

The certificate of need, for several years, has been one tool of several the state uses to achieve these goals. THE CON program is intended to promote responsible health facility and service development and to contain health care costs. Proposed projects are evaluated, using regulatory standards, to determine whether or not sufficient need exists in a community to support the addition of new health care facilities or services.

The department will work with legislators/stakeholders throughout the legislative process to evaluate the impact of the proposed legislation as it moves through the legislature. In addition, regardless of the outcome of the legislation this session, the Health Care Strategies Planning Council will likely consider this issue, among many other health care issues related to access, cost and quality of care. The Council will form this month and begin meeting shortly thereafter.
A report by the Council is due to the Governor on Jan. 1, 2008.

Thank you, Anna

Anna Kim, Special Staff Assistant
Office of the Governor

Anna Kim

From: Anna Kim [anna_kim@gov.state.ak.us]
Sent: Monday, February 26, 2007 3:18 PM
To: 'larrystinson@hotmail.com'
Cc: 'Wade_Hoek@gov.state.ak.us'
Subject: Certificate of Need

Larry,

Thank you for writing Governor Palin regarding CON issue.

I wanted to let you know that the administration will be addressing this highly visible issue. It will take time though, but will not be ignored.

Thanks, Anna

Anna Kim, Special Staff Assistant
Office of the Governor

Wade Hoek

From: Governor Sarah Palin [governor@gov.state.ak.us]
Sent: Monday, February 26, 2007 2:11 PM
To: 'Larry Stinson'
Subject: RE:

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

From: Larry Stinson [mailto:larrystinson@hotmail.com]
Sent: Monday, February 26, 2007 5:49 AM
To: kris_perry@gov.state.ak.us; sarah_palin@gov.state.ak.us; sean_parnell@gov.state.ak.us
Subject:

Governor and Lt. Governor:

AP report from February 21 titled "Economists: Health care expenses to grow" cites Federal Health and Human Services Secretary Mike Leavitt as saying "The only force strong enough to change the course of health care is a marketplace where consumers have the information and incentive to choose quality and keep costs low."

This is consistent with revising/removing CON restrictive, monopolistic trade practices and transparency in medical billing/costs.

Alaska needs a change.

Larry Stinson, M.D.

file
Pro Repeal

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Tuesday, January 29, 2008 1:02 PM
To: snowbell71@gci.net
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Tuesday, January 29, 2008 12:27 PM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Pro repeal CON

Web mail from: Ms. Jill Neff
address: PO Box 82464 Fairbanks AK 99708
907-488-4747

MESSAGE:
Dear Governor Palin,

I read today in the Fairbanks Daily News Miner with great disgust over Reps. Kelly and and Wilson opposition to removal of the CON. Apparently neither of these individuals have attempted to schedule a medical appointment in Fairbanks.

It is apparent that with Rep. Kelly's seat on the FMH foundation board, that he has an interest in keeping the CON in full force for the better of FMH but to the inconvenience of Fairbanks residents in need of medical care. His concern is that medical providers would be able to "cherry pick" medical services. That is already happening now. The clinics inform patients that a referral will have to be made to see if a case can be taken. Removing the CON will eliminate that "cherry picking". Competition is healthy. With Banner Health's purchase of Tanana Valley Clinic, it would appear that Fairbanks has a monopoly of health care developing.

The medical offices claim there is a shortage of doctors. If there is such a shortage (and there truly is), then the CON needs to be removed now. The interior needs more health care; not a noose tied around the necks of the residents.

The interior's harsh winters already puts Fairbanks at a disadvantage when trying to lure competent medical professionals to the Fairbanks North Star Borough. Many of these professionals who might be willing to brave our winter weather and open a practice then have to jump through hoops because of the CON and enormous pressure from Fairbanks Memorial Hospital. Given all that, why would any new doctors want to set up shop in Fairbanks?

I personally would rather see the residents of the interior receive quality medical care right here, in our community instead of having to travel to Anchorage, Seattle or beyond. Governor Palin, your statement that removing the CON would increase competition and decrease prices is correct. We would save on the cost of airfare!

We would also be able to receive quality medical care without having to wait 2 months for an appointment. The only other option is an urgent care facility or the hospital. Now isn't that convenient? The one entity (FMH) with the stroke to keep new medical care out is the one that directly benefits.

Thank you for your service and time.

Sincerely,
Jill Neff
Fairbanks

snowball71@gci.net

File
Doesn't Support Repeal.
Supports compromise

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Monday, February 11, 2008 7:51 AM
To: Thomas Imboden
Subject: RE:

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

From: Thomas Imboden [mailto:trigbay@starband.net]
Sent: Sunday, February 10, 2008 12:12 PM
To: Governor Sarah Palin (GOV sponsored)
Subject:

Thomas Imboden
P.O. Box 214
Gustavus, Alaska 99826
907 697.2425
trigbay@mail.com
February 7, 2008

Governor Sarah Palin
State Capital, third floor
Juneau, Alaska 99801
Governor@gov.state.ak.us

Dear Governor Palin:

Your recent State of the State speech provided numerous ideas for a comprehensive path for Alaska to follow in the twenty-first century. Included in your presentation, if I understand correctly, was a proposal to eliminate the Alaska Certificate of Need Program (CON). The focus of the following brief is imaging technologies and Ambulatory Surgical Centers (ASC). The following is submitted in response to your proposal.

The National Health Planning and Resources Act of 1974 provided the basis for the CON programs throughout the United States. The several states have had different experiences concerning the implementation and/or the abandonment of the program. Although implementation has fallen short of the ideal as manifested in the 1974 act the CON programs are valuable. As of 2004 there were thirty-six programs. Generally, the primary limitation of the efficacy of the program is the inherent politicalization and bureaucratization of the CON regulatory process. Mitigation of political intrusion within any given CON program is desirable, although total mitigation is not attainable. The process of the evaluation based on CON should go forward with the acknowledgement that politics will be a major component of the processes and that statesmanship is required. Costly expenditures and the expectation of significant financial rewards drive the political and medical economic processes. Also, bureaucratic processes have detrimentally influenced the implementation of the CON. Governmental activity in the health care industry, including the delivery of health care, is clearly in the interest of health care consumers. The action or non-action of the state will directly contribute to the overall cost of health care to the consumer. Those states that have abolished CONs have revisited the prudence of such actions.

There have been numerous studies of Certificate of Need. Some of the studies clearly show that CONs are

needed though some suggest that there are problems with how they have been implemented.[1] The primary issue to be asked in Alaska should be: What is best for the health care consumer? The Blue Cross Blue Shield Association commissioned a study concerning the efficacy of CONs[2].

The Blue Cross Blue Shield study found that Magnetic Resonance Imaging (MRI) and Computer axial tomography (CT, CAT) act as complements to one another. The increased availability of MRI and CAT are associated with an increase use with the other (vice versa) imaging technology. CAT and MRI imaging represent significant capital expenditures. Capital investment for a CT scanner typically runs 1.2 million dollars. Typical capital investment for a MRI scanner is 1.35 million dollars. (2005 dollars) The above capital outlay does not include installation and facility construction[3]. There are additional costs associated with advanced training of radiographers. Advanced training is required of the radiographer. Advanced training and certification will also increase the compensation package for the technician and thus the overall cost of each procedure. Decreased utilization of imaging machines, due to low geographic population densities, will also impact the cost per image.

Also troubling is the report by The American College of Radiology "that the majority of diagnostic imaging examinations performed outside hospitals in the United States are not performed by radiologists[4] and that in recent years, there has been a sticking increase in the number of complex, high-cost imaging exams performed by nonradiologists as compared to those performed by radiologists.[5] "Overall, the utilization rate of advanced, high-technology imaging is increasing among both radiologists and nonradiologists. However, it is *increasing* at a considerably more rapid rate among *nonradiologists.*"[6] (Italics added)

Commercial and Medicare Part B beneficiaries may be subject to over utilization of non-invasive diagnostic imaging (NDI) services. Currently, Medicare beneficiaries must meet their annual deductible and their twenty percent co-insurance (co-pay) for out-patient services. Generally, those with Medicare Part B benefits have a lower disposable income level which predisposes them to a health care delivery deficit and financial hardship. In addition, elderly beneficiaries often acquiesce to the recommendation and authority of their physician(s) without due reflection of the alternatives presented and thus the overall benefits to be achieved. The scenario(s) as presented in the mass media strongly suggests that technology is the panacea for the majority, if not all, of medical ills, rather than relaying on the art of medicine by the practitioner and long established technologies.

Studies of non-imaging technologies e.g., percutaneous transluminal coronary angioplasty, indicate that availability (or scarcity of facilities) and overall cost is not a significant factor. Studies have been completed, that included CMS beneficiaries, which would support a free market approach for those procedures. This would support the argument that current technologies that require a CON prior to construction and/or implementation need not be included in a reform CON "package". However, judicious examination of the specific technology should be done prior to their elimination from any CON process.

Other areas of responsibility of the CON process are construction authorization of new health facilities and modernization of existing hospital facilities. The CON is intended to eliminate unnecessary duplication of existing health care service facilities and thus reduce overall health care costs. Many states have found that traditional full service hospitals are compromised in their mission due to several factors including competition with Ambulatory Surgical Centers and specialty hospitals. Many communities have found that the traditional full service hospital has been replaced by specialty hospitals. Mr. Gary Barnett testified before the Illinois Health Facilities Planning Board on February 22, 2007. His testimony included the following: "When I moved from Kansas to Illinois in1998, there were two full service hospitals in the city of Wichita, Kansas. Between 1999 and 2003, two heart hospitals, one spine hospital, and two surgical hospitals opened. Today, Wichita, with a population of 530,000 people, has 2 full service hospitals, 2 heart hospitals, 1 spine hospital, 2 surgical hospitals, 8 ambulatory surgery

PREPARED STATEMENT OF
THE FEDERAL TRADE COMMISSION

Before the

STANDING COMMITTEE on HEALTH, EDUCATION & SOCIAL SERVICES

of the

ALASKA HOUSE OF REPRESENTATIVES

on

House Bill 337, "An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; relating to the certificate of need program for certain health care facilities; and providing for an effective date."

February 15, 2008

I. Introduction

The Federal Trade Commission (FTC) is pleased to have the opportunity to discuss health care competition, Alaska's certificate of need (CON) laws, and Alaska House Bill 337 (H.B. 337), which would modify certain of Alaska's CON laws.[1] The Commission believes that CON laws such as Alaska's can be a barrier to entry to the detriment of health care competition and health care consumers, and that the legislature should consider their repeal. The Commission's conclusion is based on the joint FTC/Department of Justice (DOJ) report, *Improving Health Care: A Dose of Competition* (Report or FTC/DOJ Report),[2] its underlying research, and recent work by FTC staff and the staffs of our sister agencies, such as DOJ and the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services. As noted in the FTC/DOJ Report, "[t]he Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[3]

Congress has charged the Commission with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[4] Pursuant to its statutory mandate, the FTC seeks to identify business practices and regulations that

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[1] The FTC initially was invited to submit testimony regarding H.B. 337, as introduced on January 22, 2008, which would have repealed Alaska's CON requirements generally, a more recent committee substitute draft also before the relevant Alaska house committee (but not yet available publicly) would repeal only certain of Alaska's CON requirements, but leave others – such as those regarding nursing homes – intact.

[2] FEDERAL TRADE COMMISSION & THE DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July, 2004) [hereinafter "IMPROVING HEALTH CARE"].

[3] *Id.* at Executive Summary, p. 22.

[4] Federal Trade Commission Act, 15 U.S.C. § 45.

impede competition without offering countervailing benefits to consumers. For several decades, the FTC and its staff have investigated the competitive effects of restrictions on the business practices of health care providers.[5] Included in that general body of health care competition work have been hearings, studies, and reports addressing issues raised by CON laws.

Specifically, the FTC/DOJ Report discusses critically the role of CON laws in health care competition, both as a distinct policy issue and as an important component of other health care competition issues, such as entry problems in hospital markets. The Report broadly examined the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying the preferences of Americans for high-quality, cost-effective health care. The Report was based on, among other things, joint FTC/DOJ hearings that took place over 27 days from February through October 2003, following a Commission-sponsored workshop on health care issues in September 2002. The FTC and DOJ heard testimony from about 240 panelists, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from antitrust and economics to health care quality and informed consent. Together, the hearings and workshop elicited written submissions from interested parties. Almost 6,000 pages of transcripts of the hearings and workshop and all written submissions are available on the Commission website, www.ftc.gov. In addition, FTC and DOJ staffs undertook independent research for the Report.

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[5] *See* Federal Trade Commission, *FTC Antitrust Actions in Health Care Services and Products* (Oct. 2003), *available at* http://www.ftc.gov/bc/hcupdate031024.pdf

In this testimony, the Commission focuses specifically on a few of the issues discussed in the Report that address CON laws and new entry into competition among health care facilities. Three main points require attention:

- First, vigorous competition among healthcare providers, such as hospitals, clinics, and nursing homes, usually benefits consumers through better and more varied services and, in some cases, lower prices. CON laws were designed to create barriers to entry for new healthcare facilities or providers to contain the costs of healthcare services. CON laws, however, have not been particularly effective in controlling healthcare costs, while posing significant risks to competition. In particular, CON laws can retard the entry of firms that could provide higher quality services or lower prices than those offered by incumbents, depress consumer choice between qualitatively different treatment options or settings, or reduce the pressure on incumbents to improve qualitative aspects of their own offerings. Policymakers would be wise to consider reviewing all of the actual costs, benefits, and consequences – intended and unintended – of a regulatory system when assessing that system's future.
- Second, the CON regulatory system creates both the incentive and means by which an incumbent healthcare provider can use the regulatory system itself to delay effective competition, independent of the demand for additional healthcare services. This additional loss of competition is another regulatory cost that must be weighed in the balance when assessing the public interest.

- Finally, Alaska currently has one of the most stringent CON laws in the United States. House Bill 337's proposed amendment of this law would eliminate or reduce barriers to entry for a broad range of healthcare service providers, including small entities that might then be able to thrive as never before.

These points are addressed more fully, below.

II. Discussion

A. Provider Competition Generally: Competition has important benefits in health care services markets, just as it has in the multitude of markets in the U.S. economy that rely on competition to maximize the welfare of consumers. Competitive pressures can lead hospitals and other entities to lower costs, improve quality, and compete more efficiently. In particular, competitive pressure may spur new types of competition. In some hospital markets, new entrants specialize and provide only a limited portion of the in-patient and out-patient services that general hospitals tend to provide.[6] Elsewhere, health care services once delivered only in large hospitals – and requiring overnight stays – may be performed more conveniently and less invasively, at lower cost, in outpatient settings. In addition, both traditional providers and new entities have explored new means to expand access to basic health care by, for example,

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[6] *See generally Prepared Statement of the Federal Trade Commission, Before the S. Subcomm. On Federal Financial Management, Gov't Information and Int. Security of the S. Comm. on Homeland Security and Governmental Affairs, on New Entry Into Hospital Competition* (May 24, 2005) (regarding, e.g., new specialty hospital entry), *available at* http://www.ftc.gov/os/2005/05/052405newentryintohospitalcomp.pdf; *see also* UNITED STATES DEPT. OF HEALTH AND HUMAN SERVICES, FINAL REPORT TO THE CONGRESS AND STRATEGIC IMPLEMENTING PLAN REQUIRED UNDER SECTION 5006 OF THE DEFICIT REDUCTION ACT OF 2005 (2006) [hereinafter "HHS FINAL REPORT"], *available at http://www.cms.hhs.gov/PhysicianSelfReferral/06a_DRA_Reports.asp*.

establishing limited service clinics that can provide more convenient and lower cost care and bring more consumers into contact with the larger health care system.[7]

Although new strategies for lowering costs and enhancing quality are emerging, competition is not as effective as possible in most health care markets, because the prerequisites for competitive markets are not fully satisfied. Of particular concern for today's purpose is the extent to which state regulations can create barriers to entry in health care markets, without conferring countervailing benefits in quality of care or cost containment.[8]

At the same time, the empirical evidence generally does not indicate that CON laws control health care costs.[9] Recent broad studies analyzing both national and state

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[7] *See, e.g.*, FTC Staff Comment Before the Massachusetts Department of Public Health Concerning Proposed Regulation of Limited Service Clinics, 1-2 (Oct. 2007)

[8] In discussing competition concerns raised by CON requirements, the Commission does not mean to suggest that state CON regulations are the only regulatory impediments to competitive forces in health care markets. For example, in testimony before the House Committee on Energy and Commerce on May 12, 2005, Mark McClellan, then Administrator of CMS, reported that CMS, following its own study of specialty hospitals pursuant to congressional direction, would analyze and reform its payment rates "to help reduce the possibility that specialty hospitals may take advantage of imprecise payment rates in the inpatient hospital prospective payment system" and "to diminish the divergences in payment levels [for ambulatory surgical centers] that create artificial incentives for the creation of small orthopedic or surgical hospitals." *Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, Before the H. Comm. on Energy and Commerce Hearing, "Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care,"* (May 12, 2005), *available at* http://www.hhs.gov/asl/testify/t050512.html; *see also Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, on Physician-Owned Specialty Hospitals Before the S. Finance Comm.* (May 17, 2006), *available at http://www.hhs.gov/asl/testify/t060517b.html*

[9] IMPROVING HEALTH CARE, *supra* note 2, at C. 8, at pp. 1-6. Although the larger body of CON literature – including anecdotal reports and small, uncontrolled studies – presents somewhat mixed conclusions on cost savings, the conclusions of the FTC/DOJ Report and staff research have substantially been borne out by more recent, sophisticated large-scale data analyses and literature reviews: "[O]n balance, the most methodologically sound studies have found that CON has no effect or actually increases both hospital spending per capita and total spending per capita." CHRISTOPHER J. CONOVER & FRANK A. SLOAN, EVALUATION OF CERTIFICATE OF NEED IN MICHIGAN, CENTER FOR HEALTH POLICY, LAW AND MANAGEMENT, TERRY SANFORD INSTITUTE OF PUBLIC POLICY, DUKE UNIVERSITY, A REPORT TO THE MICHIGAN DEPT. OF COMMUNITY HEALTH, 30 (May 2003) (reviewing literature and discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws) (hereinafter "CONOVER & SLOAN, REPORT TO MICHIGAN"); WASHINGTON STATE JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE (JLARC), EFFECTS OF CERTIFICATE OF NEED AND ITS POSSIBLE REPEAL, 1 (Jan. 8, 1999) ("The study found that CON has not controlled overall health care spending or hospital costs.

data reveal "little evidence that CON results in a reduction in costs and some evidence to suggest the opposite."[10] Studies also fail to show any consistent increase or surge in health care spending when states remove or modify their CON requirements.[11]

Barriers to entry can affect qualitative competition as well. As the Report noted, state CON laws can retard the entry of firms that could provide higher quality services than those offered by incumbents.[12] That may tend to depress consumer choice between qualitatively different treatment options or settings,[13] or it may reduce the pressure on incumbents to improve qualitative aspects of their own offerings.

The study generally found either conflicting or limited evidence about the effects of CON on the cost of non-hospital services, and on the quality and availability of the various health care services.") DANIEL SHERMAN, FEDERAL TRADE COMMISSION, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS, iv, 58-60 (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data on 3,708 hospitals, that strong CON programs do not lead to lower costs but may actually increase costs); MONICA NOETHER, FEDERAL TRADE COMMISSION, COMPETITION AMONG HOSPITALS 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); KEITH B. ANDERSON & DAVID I. KASS, FEDERAL TRADE COMMISSION, CERTIFICATE OF NEED REGULATION OF ENTRY INTO HOME HEALTH CARE: A MULTI-PRODUCT COST FUNCTION ANALYSIS (1986) (economic study finding that CON regulation led to higher costs, and that CON regulation did little to further economies of scale). *But c.f.*, COMMONWEALTH OF VIRGINIA, REPORT OF THE JOINT COMMISSION ON HEALTH CARE, HOUSE DOC. NO. 82, STUDY OF VIRGINIA'S CERTIFICATE OF PUBLIC NEED (COPN) PROGRAM PURSUANT TO HB 1302 OF 1996 (1997), ("There is little evidence of significant COPN impact on aggregate health expenditures, but there is evidence of savings for specific services covered by COPN"). *Id.* at 1, *available at* http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD821997/$file/HD82_1997.pdf?bcsi_scan_129F6A3CDB83467E=xLesgwMDZ3sPV18TFUnlHEQAAAD+Q30W&bcsi_scan_filename=HD82_1997.pdf (last checked 1/31/08).

[10] CONOVER & SLOAN, REPORT TO MICHIGAN, *supra* note 9 at vii (discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws); *id.* at 30-31.

[11] CONOVER AND SLOAN also report that, "[i]n most states that lifted CON, per capita spending on hospital and physician services (relative to the US) has remained below the U.S. average following removal of CON.") *Id.* at 50; *see also* Christopher J. Conover and Frank A. Sloan. *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL'Y & LAW 455 (1998) ("no evidence of a surge in acquisition of facilities or in costs following removal of a CON.") 458.

[12] IMPROVING HEALTH CARE, *supra* note 2, at C. 8, p. 4 (citing Hosp. Corp. of Am., 106 F.T.C. 361, 495 (1985) (Opinion of the Commission) (stating that "CON laws pose a very substantial obstacle to both new entry and expansion of bed capacity in the Chattanooga market" and that "the very purpose of the CON laws is to restrict entry").

[13] With regard to hospital markets, *see, e.g.*, HHS FINAL REPORT, *supra* note 6, at 10 (reporting "quality of care at least as good as, and in some cases better than, care provided at local competitor hospitals" for

B. Incumbent Lobbying and Petitioning Protections: When new firms threaten to enter a market, incumbent firms may seek to deter or prevent that new competition. Such conduct is by no means unique to health care markets; it is a typical reaction of incumbents to possible new competitors. In certain circumstances, such conduct may violate the antitrust laws.[14] Certain anticompetitive conduct may, however, be shielded from antitrust scrutiny. The *Noerr-Pennington* doctrine immunizes from antitrust liability conduct that represents petitioning the government, even when such petitioning is done "to restrain competition or gain advantage over competitors."[15] Moreover, the state action doctrine shields from antitrust scrutiny many of a state's own activities when a state government is acting in its sovereign, legislative capacity.[16]

In the context of health care competition, the combination of these two doctrines can offer antitrust immunity to providers that wish to lobby state officials to impede the entry of potential competitors, by denying or delaying the CONs required for operation. State CON programs generally prevent firms from entering certain areas of the health

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cardiac care, as well as "very high" patient satisfaction in cardiac hospitals and orthopedic specialty hospitals) (citations omitted). In addition, specialty hospitals appear to offer shorter lengths of stay, per procedure, than peer hospitals. *See* MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS, 15-17 (Mar. 2005) (hereinafter MEDPAC REPORT). MedPAC was directed to report to Congress on certain issues regarding specialty hospitals under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. *Id.* at vii.

[14] *See* IMPROVING HEALTH CARE, *supra* note 2, at 15-16, ch 1, at 31-33, ch 3, at 22-27.

[15] Andrx Pharm. V. Biovail, 256 F.3d 799, 817 (D.C. Cir. 2001), *cert. denied*, 122 S. Ct. 1305 (2002). The doctrine is named for the seminal cases that treated it: Eastern R.R. Presidents Conference v. Noerr, 365 U.S. 127 (1961), and United Mine Workers v. Pennington, 381 U.S. 657 (1965).

[16] Parker v. Brown, 317 U.S. 341, 351 (1943). The state action doctrine also immunizes from antitrust scrutiny the actions of other entities and individuals if they are acting in furtherance of a clearly articulated state policy and are actively supervised by the state. *See, e.g.*, California Retail Liquor Dealers Assn. v. Midcal Aluminum, 445 U.S. 97, 105 (1980)

care market unless they can demonstrate to state authorities an unmet need for their services. Because that demonstration can be time-consuming and costly, it may delay or, at the margin, prevent the introduction of certain needed facilities and services.[17] Indeed, limiting competitor entry and raising competitors' costs may both be incentives for incumbents to seek to abuse the regulatory process. The FTC/DOJ Report concluded that "incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market."[18] To the extent they are successful in doing so, incumbents may preserve their market shares and revenue streams without enhancing their own operating efficiency or providing health care savings to the state or its consumers.[19]

C. **The Scope of Alaska CON Law:** Alaska's current CON law is among the most stringent of such laws in the United States. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974,[20] which offered states powerful incentives to enact laws implementing CON programs.[21] By 1980, all states except Louisiana had done so.[22]

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[17] *See, e.g.*, IMPROVING HEALTH CARE, *supra* note 2, at C. 4, p. 25 (noting that approval of a CON "can take anywhere from 18 months to several years," and that regulatory delays from CON approval are in addition to those imposed by, for example, traditional licensing requirements).

[18] *Id. at* Exec. Summ., at 22.

[19] *See, e.g.*, MEDPAC REPORT at 10-11 ("Some community hospital administrators admit that competition with specialty hospitals has had some positive effects on community hospitals' operations").

[20] Pub. L. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k-300n-5), *repealed*, Pub. L. 99-660, § 701, 100 Stat. 3799 (1986).

[21] *See* JOHN MILES, 2 HEALTH CARE & ANTITRUST LAWS: PRINCIPLES & PRACTICE § 16:1, at 16-2 (2003) (noting that the federal Health Planning Act required providers to "obtain state approval – a 'certificate of need' – before spending set amounts on capital investments or adding new health care services.")

[22] *See, e.g., On Certificate of Need Regulation: Hearing on H.B. 332 Before the Senate Comm. On Health and Human Services* (Ohio 1989) (Statement of Mark D. Kindt, FTC Regional Director).

Congress repealed the federal law in 1986, however, and many states have repealed or revised their CON laws in the years since. Fourteen states have eliminated their CON requirements altogether[23] and, although a substantial number of states continue to maintain CON programs,[24] they do so "often in a loosened form compared to their predecessors."[25] Remaining CON laws may address only specific types of health care facilities – such as hospitals or nursing homes,[26] – exempt certain types of health care facilities,[27] or apply broadly to health care facilities improvements of a greater magnitude.[28] In addition, certain CON laws may be pending repeal according to a sunset provision.[29]

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[23] *See, e.g.*, National Conference of State Legislatures, *Certificate of Need: State Health Laws and Programs* (updated Nov. 2007) (CON laws repealed or not in effect in CA, AZ, NM, TX, KS, CO, UT, WY, ID, SD, ND, MN, IN, and PA), *available at* http://www.ncsl.org/programs/health/cert-need.htm (last checked 01/25/08).

[24] MILES, *supra* note 21, § 16:2, at 16-9 (stating that "CON laws remain in many states and the District of Columbia"). Quite recently, Florida exempted from CON requirements new adult open-heart surgery and angioplasty programs at general hospitals and the addition of beds to existing hospital structures. Fla. Bill SJ 01740 (effective July 1, 2004), *amending* FLA STAT. ch. 408.036, .0361 (2003).

[25] MILES, *supra* note 21, § 16:1, at 16-2 to 16-3. *See also* Len M. Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning*, 23 HEALTH AFFAIRS 1, 11 (Mar./Apr. 2004) (noting that CON programs "eroded through the 1990s").

[26] *See, e.g.*, OAC Ann. 3701-12-05 (2007) (regarding only certain activities by "long-term care" facilities in Ohio); R.R.S. Neb. § 71.5829.03 (2007) (CON covers only certain activities related to long-term care and rehab beds in Nebraska); ORS § 442.315(1) (2005) (regarding "any new hospital or new skilled nursing or intermediate care service or facility" in Oregon, subject to certain exclusions).

[27] For example, Connecticut law exempts critical access hospital beds and related equipment from the State's CON laws. *See* Conn. Gen. Stat. § 19a-487a (2007); *see also* Fla. Stat. § 408.0361 (2007) (regarding cardiovascular services and burn unit licensing); Fla. Stat. § 408.036 (2007).

[28] For example, Connecticut health care facilities must obtain a CON prior to developing, expanding or closing certain services and expending more than $3 million on a capital project. Conn. Gen. Stat. § 19a-638(a)(4) (2007); Delaware requires a CON for the establishment of a new facility, but only for capital expenditures by existing facilities in excess of $5.8 million (or a higher amount based on inflation adjustments to the $5.8 million baseline). *See* 16 Del. C. § 9304 (2007).

[29] *See, e.g.* 16 Del. C. § 9311 (2007) (sunset provision).

Alaska law requires a CON for any type of health care facility construction or improvement of $1,000,000 or more, adjusted,[30] or the establishment of a nursing home facility independent of that cost threshold.[31] In so doing, it places significant regulatory burdens on the development or improvement of a very broad class of health care facilities – not just major hospital initiatives and expansions, which may be subject to long-term planning – but diverse outpatient clinic initiatives, which might otherwise develop dynamically in response to market needs. The scope of current Alaska law thus stands in contrast not only to the laws of those states that have eliminated their CON requirements altogether, but the laws of the many states that have more limited CON requirements. Alaska's low CON threshold itself may be a special burden to the State's health care spending, as low CON thresholds have been observed to increase costs – relative to higher thresholds – rather than decrease them.[32]

A degree of controversy may remain about particular issues addressed by certain CON laws. These include, for example, efficiency and possible conflicts of interest concerns about certain categories of physician-owned specialty hospitals and access issues for rural or other underserved areas.[33] However, the sweep of Alaska's CON law

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[30] Alaska Stat. § 18.07.031(a) (2007). The statute contains an adjustment provision, whereby the $ 1 million dollar threshold may be increased by $50,000 per anum, between 2005 and 2014. *Id.* at § 18.07.031(d).

[31] *Id.* at § 18.07.031(b).

[32] *See* SHERMAN, *supra* note 9, at 58-60 (1.4 percent decline in costs associated with doubling of all thresholds).

[33] *See, e.g.*, Testimony of Mark B. McClellan, M.D., Ph.D. (2005), *supra* note 8; Testimony of Mark B. McClellan, M.D., Ph.D. (2006), *supra* note 8 (regarding CMS studies of physician-owned specialty hospitals, implementation and termination of limited moratorium on new specialty hospitals). The Commission does not here intend to analyze the details of ongoing regulatory reform at CMS designed to address special concerns about certain limited types of specialty hospitals (and related physician self-referral issues) or the various bodies of research on which those reforms are based. The FTC notes, simply,

is much broader than required to address any of those more narrow and complex issues and is likely to be detrimental to Alaska's health care consumers. The Commission recommends that Alaska carefully consider the evidentiary basis of these issues as they may relate to Alaska health care consumers. If the evidence and public policy considerations warrant some legislative action, the Commission recommends that Alaska consider regulation that is narrowly tailored to achieve focused health policy goals instead of broad regulation of entry into the market for health care facilities.

III. Conclusion

CON laws were adopted throughout most states under particular market and regulatory conditions substantially different from those that predominate today and were intended to help contain health care spending. The best available research does not support the conclusion that CON laws actually reduce such expenditures. As the FTC and DOJ have said, "on balance, CON programs are not successful in containing health care costs, and ... they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[14] CON laws tend to create barriers to entry for health care service providers who may contribute to qualitative competition and provide consumers with important choices in the market, but CON laws do not, on balance, tend to suppress health care costs or aggregate health care spending. Moreover, CON laws may be especially subject to abuse by incumbent providers, who can seek to exploit a state's CON process to forestall the entry of competitors in their markets.

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that most of the actual and potential health care entities subject to Alaska CON law are not such specialty hospitals and appear to fall outside the concerns driving those studies and reforms.

[14] IMPROVING HEALTH CARE, *supra* note 2, at Executive Summary, p. 22.

Alaska's current CON law – which House Bill 337 seeks to modify – is among the most stringent of such laws in the United States. As a consequence, Alaska CON law creates a barrier to entry for a very broad range of health care service providers, including small health care entities that may be ill-equipped to overcome it. The Commission believes that both the breadth of Alaska's CON law, and its low threshold, are of special concern, as they may work to the detriment of Alaska health care consumers. In the event that adequate evidence develops to support more narrow policy priorities, the Commission believes that Alaska should consider regulations narrowly tailored to meet those priorities, while minimizing the general costs to Alaska health care consumers.

Competition in Healthcare and Certificates of Need

JOSEPH M. MILLER
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U.S. Department of Justice, Antitrust Division

January 31, 2008[1]

Good afternoon. I appreciate the invitation to the Antitrust Division of the U.S. Department of Justice to share our views on the impact of Certificate of Need ("CON") laws on healthcare markets.

My name is Joseph Miller. I am the Assistant Chief of the Litigation I Section of the Antitrust Division. The Litigation I Section enforces the antitrust laws in a wide variety of industries, including healthcare markets. Our attorneys confer closely with a large team of economists holding doctorates in the study of markets and their performance, including a number with specialization in the performance of healthcare markets. We also confer closely with the attorneys and economists at the Federal Trade Commission, who have dedicated time to the study of healthcare markets.

The Antitrust Division and the FTC have investigated and litigated antitrust cases in markets across the country involving hospitals, physicians, ambulatory surgery centers, stand-alone radiology programs, medical equipment, pharmaceuticals and other healthcare products. Through that work we have developed a substantial understanding of the competitive forces that drive innovation in and contain the costs of healthcare. We regularly issue informal advisory letters on the application of the antitrust laws to healthcare markets, and periodically issue reports and general guidance to the healthcare community. For example, in 2003, we conducted 27 days of hearings on competition and policy concerns in the healthcare industry, heard from approximately 250 panelists, elicited 62 written submissions, and generated almost 6,000 pages of transcripts.[2] As a result of that effort, we published an extensive report, entitled *Improving Health Care: A Dose of Competition*, in July 2004.

I. Scope of Remarks

The Antitrust Division's experience and expertise has taught us that Certificate of Need laws pose a substantial threat to the efficient performance of healthcare markets. By their very nature, CON laws create barriers to entry and expansion and thus restrict free and open

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[1] This paper draws significantly from testimony delivered on behalf of the Antitrust Division to the General Assembly and Senate of the State of Georgia on February 23, 2007.

[2] This extensive hearing record is largely available at http://www.ftc.gov/bc/healthcare/research/healthcarehearing.htm.

competition. They undercut consumer choice, weaken markets' ability to contain healthcare costs, and stifle innovation.

We have examined historical and current arguments for CON laws, and conclude that such arguments provide no economic justification for depriving consumers' of the benefits of free markets. To the extent that CONs are used to further non-economic goals, they impose substantial costs. Such goals, purportedly furthered through CON laws, can be more efficiently achieved through other mechanisms. We hope you will carefully consider the substantial costs that CON laws impose on consumers as you evaluate whether to eliminate those laws in Alaska.

I do not testify today to discuss the details of the legislation you are considering. I am, however, generally familiar with the issues before you and recognize them as issues that CON laws present in other states and other markets. My remarks, accordingly, will focus on the impact of and justifications for CON laws generally.

It is not the Antitrust Division's intent to "favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, [our] goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices . . ."[3] Our overall mission is to preserve and promote economic competition rather than to preserve any particular marketplace rival or group of rivals.

II. Importance of Competition and the Harm Caused by Regulatory Barriers to Entry

A. The Benefits of Competition in Healthcare

Our concerns about the harm from CON laws are informed by one fundamental principle: market forces improve the quality and lower the costs of healthcare services. They drive innovation and ultimately lead to the delivery of better healthcare. Government intervention can undermine market forces to the detriment of healthcare consumers.

In our antitrust investigations we often hear the argument that healthcare is "different" and therefore competition principles do not apply to the provision of healthcare services. The proposition that competition cannot work in healthcare is simply not true. Engineers and lawyers have made similar arguments that competition does not work in their industries and, in fact undermined other social goods advanced by their professions. Such arguments have been rejected by the courts, and private restraints on competition have long been condemned.[4] Indeed, at least since the Supreme Court's seminal 1943 decision in a case brought by the Department of Justice against the American Medical Association, competition has played a critical role in

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[3] Statements of Antitrust Enforcement Policy in Health Care, August 1996, Introduction, pg. 3 (available at: http://www.usdoj.gov/atr/public/guidelines/1791.htm).

[4] *F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990); *National Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978).

shaping the delivery of healthcare in this country.[5] The Antitrust Division and the Federal Trade Commission have worked diligently to make sure that private barriers to that competition do not arise.

During our extensive healthcare hearings in 2003, we obtained substantial evidence generally about the role of competition in our healthcare delivery system and reached the conclusion that vigorous competition among healthcare providers "promotes the delivery of high-quality, cost-effective healthcare." Specifically, competition results in lower prices and broader access to health care and health insurance, while non-price competition can promote higher quality.[6]

This finding is not new. We saw in the 1990s the growth of managed care and the impact it had on the cost and availability of insurance. Competition among and between hospitals and physicians intensified with the development of managed care organizations. In addition to putting pressure on costs, managed care plans have pressured providers to use shorter hospital stays and to offer alternative outpatient treatments. This evolution in health care purchasing led to lower costs and increased choice without sacrificing quality. Moreover, lower costs and improved efficiency made health insurance more affordable and available.

Competition also helped bring to consumers important innovations in healthcare technology. For example, health plan demand for lower costs and "patient demand for a non-institutional, friendly, convenient setting for their surgical care" drove the growth of Ambulatory Surgery Centers (ASCs). [7] Ambulatory surgery centers offered patients more "convenient locations, shorter wait time, and lower coinsurance than a hospital department."[8] Important to the success of these competitive forces in improving the delivery of care to consumers was the availability of technological advances, such as endoscopic surgery and advanced anesthetic agents.[9] Thus, competition harnessed this new technology and brought it to consumers in the lower cost, more convenient setting of ambulatory surgery centers. The impact on traditional general acute care hospitals led to those hospitals responding to the competition by delivering more care, in a better manner, in an outpatient setting, both at their own campuses and at ambulatory surgery centers in which they invested.

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[5] *American Medical Association v. U.S.*, 317 U.S. 519, 529 (1943).

[6] *Improving Health Care: A Dose of Competition*, ch. 3 § VIII and Executive Summary at 4 (July 2004) available at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf. ("*A Dose of Competition*").

[7] Id., Ch. 3 at 25.

[8] Medicare Payment Advisory Commitions (MedPAC), Report to the Congress: Medicare Payment Policy § 2F, at 140 (2003), available at http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf.

[9] A Dose of Competition, at ch. 3 at 24.

This type of competitive success story has occurred again and again in healthcare in the area of pharmaceuticals, urgent care centers, and elective surgeries such as Lasik procedures, to name just a few. Without private or governmental impediments to their performance, we can expect healthcare markets to continue to deliver these benefits.

B. CON Laws Create Barriers to Beneficial Competition

CON laws are a classic government-erected barrier to entry, and by their nature are an impediment to the proper functioning of the market process. Accordingly, in *A Dose of Competition*, the Federal Trade Commission and we urged the states to rethink their CON laws.[10]

1. Original Cost-Control Reasons For CON Laws No Longer Apply

We made that recommendation in part because the original reason for the adoption of CON laws is no longer valid. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974, which offered incentives for states to implement CON programs. At the time, the federal government and private insurance reimbursed healthcare charges predominantly on a "cost-plus" basis, which provided incentives for over-investment. The hope was that CON laws would provide a counterweight against that skewed incentive.

In considering this historical justification for CON laws, we need to keep clear that a number of other arguments made today in support of CON laws were not part of the rationale for their original adoption –

* CON laws were not adopted as a means of cross-subsidizing care;
* CON laws were not adopted in order to have centralized planning of the location and nature of healthcare facilities; and,
* CON laws were not adopted to protect the health and safety of the population from poor quality medicine.

Instead, CON laws were adopted because excessive capital investments, spurred by the then-current cost-plus method of reimbursement, were driving up healthcare costs. There was concern that, because patients are usually not price-sensitive, providers engaged in a "medical arms race" by unnecessarily expanding their services to offer the perceived highest quality services.[11]

CON laws appear to have failed in their intended purpose of containing costs. Several studies have examined the effectiveness of CONs in controlling costs. The empirical evidence

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[10] *A Dose of Competition*, Executive Summary at 22.

[11] *A Dose of Competition*, Ch. 8, pg. 1-2.

on the economic effects of CON programs has demonstrated near-universal agreement among health economists that CON laws were unsuccessful in containing healthcare costs.[12]

In addition to the fact that CON laws have been ineffective in serving their original purpose, CON laws should be reexamined because the reimbursement methodologies that may in theory have justified them initially have changed significantly since the 1970s. The federal government no longer reimburses on a cost-plus basis. In 1986, Congress repealed the National Health Planning and Resources Development Act of 1974. Additionally, health plans and other purchasers routinely bargain with healthcare providers over prices. Essentially, government regulations have changed in a way that eliminates the original justification for CON programs.[13]

2. Protecting Revenues of Incumbents Does Not Justify CON Laws

Incumbent hospitals often argue that they should be protected against additional competition so that they can continue to cross-subsidize care provided to uninsured or under-insured patients. Under this rationale, CON laws would impede the entry of such healthcare providers as independent ambulatory surgery centers, free-standing radiology or radiation-therapy providers, single- or multi-specialty physician-owned hospitals, because if these new competitors were to enter the marketplace, community hospitals could not continue to exploit their existing market power over consumers. Put another way, without CON laws, we would see new, higher-quality, low cost providers in the marketplace, which would put competitive pressure on incumbent providers, and deprive them of revenues they could put to a charitable use.[14]

We fully appreciate the laudatory goal of providing sufficient funding for community hospitals so that these hospitals can provide healthcare services to those who cannot afford them and for whom government payments are either unavailable or too little to cover the cost of care. But, we also want to make clear that the use of government barriers to entry to fund indigent care has costs. There are more efficient ways to accomplish this goal without incurring the costs of impeding the proper functioning of health care markets. Essentially, by protecting incumbent hospitals from competition, CON laws allow dominant hospitals to tax consumers through the exercise of market power in order to pursue the charitable goal of providing care to other, less fortunate consumers. In using that funding mechanism, however, the CON laws may do more harm than good.

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[12] David S. Salkever, Regulation of Prices and Investment in Hospital in the United States, in 1B Handbook of Health Economics, 1489-90 (A.J. Culyer & J.P. Newhouse eds., 2000) ("there is little evidence that [1970's era] investment controls reduced the rate of cost growth.")

[13] *A Dose of Competition* at pg. 1-6.

[14] Note the irony of this argument: What started as laws intended to control costs have become laws intended to inflate costs. Proponents of CON laws now would use these barriers to entry to stifle competition, protect incumbent market power, frustrate consumer choice, and keep prices and profits high.

First, CON laws harm the consumers who would have chosen alternative, lower priced, higher quality, or more convenient sources of care.

Second, CON laws impose that cost without any clear evidence that other desirable social goals are advanced. The evidence to date indicates that new competition does not undercut community hospitals' ability to fulfill charitable missions. Recently the federal government studied just this issue in connection with the emergence of single-specialty hospitals around the country. The study found that, for several reasons, specialty hospitals did not undercut the financial viability of rival community hospitals.[15] One substantial reason for this was that specialty hospitals generally locate in areas that have above average population growth. Thus, they are competing for a new and growing patient population, not just siphoning off the existing customer base of the community hospitals.

Third, new competition can force community hospitals to improve their performance. In studying the effect of single-specialty hospitals, MedPAC found that the community hospitals responded to the competition by improving efficiency, adjusting their pricing, and expanding profitable lines of business.[16] Community hospitals encouraged physicians to perform procedures on the hospital campus by developing centers of excellence and building physician offices on campus.[17] Overall, community hospitals affected by specialty hospital entry maintained profit margins in line with national averages. Rather than undercutting community hospitals, new entry drives them to do a better job. Thus, in addition to the harm to the consumers who would have chosen the new healthcare provider, CON laws harm society in general by depriving it of the increased efficiency that competition would have brought to the health care market.

3. CON Laws Impose Other Costs And May Facilitate Anti-Competitive Behavior

CON laws appear to raise a particularly substantial barrier to entry and expansion of competitors because they create an opportunity for existing competitors to exploit procedural

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[15] Report to the Congress: Physician-Owned Specialty Hospitals Revisited, pp. 21-25 (August 2006), available at http://www.medpac.gov/publications/congressional_reports/Aug06_specialtyhospital_mandated_report.pdf. ("MedPAC 2006 Report") (concluding that physician-owned specialty hospitals admit a lower proportion of Medicaid patients)

[16] Other studies have found that the presence of for-profit competitors leads to increased efficiency at nonprofit hospitals. Kessler, D. and McClellan M., "The Effects of Hospital Ownership on Medical Productivity," RAND Journal of Economics 33 (3), 488-506 (2002).

[17] Greenwald, L. et al., "Specialty Versus Community Hospitals: Referrals, Quality, and Community Benefits," *Health Affairs* 25, no. 1 (2006): 116-117. *See also* Stensland J. and Winter A., "Do Physician-Owned Cardiac Hospitals Increase Utilization?" *Health Affairs* 25, no. 1 (2006): 128 (some community hospitals have responded to the presence of specialty hospitals by recruiting physicians and adding new cardiac catheterization labs).

opportunities to thwart or delay new competition. Such behavior, commonly called "rent seeking" conduct, is a well-recognized consequence of regulatory intervention in the market.[18] Essentially, an existing competitor uses the hearing and appeals process to cause substantial delays, leading both the existing competitor and the new entrant to divert significant funds away from delivering healthcare and to spend them on legal fees, consulting fees, and lobbying efforts. Moreover, much of this conduct, even if exclusionary and anticompetitive, is unlikely to be subject to legal challenge as a violation of the antitrust laws because it involves petitioning of the state government by the existing competitor.[19] Indeed, during our hearings, we received evidence of the widespread recognition that existing competitors use the CON process "to forestall competitors from entering an incumbent's market."[20]

We have found that existing competitors, at times with the encouragement or acquiescence of state officials, go further and enter into agreements not required by the CON laws but nonetheless facilitated by them. Two examples arise from West Virginia, and a third comes from Vermont.

In the first West Virginia case, we found that a Charleston, West Virginia hospital used the threat of objection during the CON process, and the potential ensuing delay and cost, to induce a hospital seeking a certificate of need for an open heart surgery program not to apply for it at the location that would have well served Charleston consumers and provided greater competition for their business.[21] Instead, the Charleston hospital successfully prevented the possibility of this competing open heart program. The state authorities never had the opportunity to decide whether under the CON laws that second program would have been approved because of the unlawful agreement among the hospitals.

In the second West Virginia case, two closely competing hospitals decided to allocate healthcare services between themselves.[22] The informal urging of state CON officials led them to agree unlawfully that only the one hospital would apply for an open heart program and only the other would apply to provide cancer services. Again, the state took no official action and consumers were deprived of the potential competition between these hospitals.

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[18] Joskow, Paul and Rose, Nancy, "The Effects of Economic Regulation." *Handbook of Industrial Organization, vol. 2*, Schmalensee and Willig, ed. Amsterdam: North-Holland, 1989.

[19] *Eastern Rail. Pres. Conf. v. Noerr Motor Frgt., Inc.*, 365 U.S. 127 (1961).

[20] *A Dose of Competition*, Executive Summary at 22.

[21] *U.S. v. Charleston Area Medical Center, Inc.*, Civil Action 2:06 -0091 (S.D.W.Va. 2006) (available at: http://www.usdoj.gov/atr/cases/f214400/214477.htm).

[22] *U.S. v. Bluefield Regional Medical Center, Inc.*, 2005-2 Trade Cases ¶ 74,916 (S.D. W.Va. 2005).

A third example comes from the State of Vermont. There, home health agencies entered into territorial market allocations, again under cover of the state regulatory program, to give each other exclusive geographic markets.[23] That state's CON laws prevented competitive entry, which normally might have disciplined such cartel behavior. We found that Vermont consumers were paying higher prices than were consumers in states where home health agencies competed against each other.

We have learned from these matters and others that CON laws have the potential to impede competition in ways well beyond what is intended by their supporters.

III. Conclusion

My remarks are intended to convey to you our belief that CON laws impose substantial costs on consumers and healthcare markets. In light of these costs, the Antitrust Division believes that Alaska should carefully consider whether on balance its CON laws do more harm than good. Let me close by encouraging you not to accept without careful scrutiny claims that elimination of CON laws will visit significant harm on your state.

Thank you again for the opportunity to discuss our views on how CON laws affect competition and consumers in healthcare. I would be happy to take your questions.

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[23] Department of Justice Statement on the Closing of the Vermont Home Health Investigation, (Nov. 23, 2005) (available at: http://www.usdoj.gov/atr/public/press_releases/2005/213248.htm).

Alaska Health, Education & Social Services Committee

Testimony on Certificate of Need

by

Robert James Cimasi
MHA, ASA, CBA, AVA, CM&AA, CMP

January 29, 2008

Testimony Related to Alaska House Bill 337: ***An Act establishing the Alaska Health Care Commission and the Alaska Health Care Information Office; relating to healthcare planning and information; repealing the certificate of need program for certain healthcare facilities; and providing for an effective date"***

January 31, 2008

By Robert James Cimasi, MHA, ASA, CBA, AVA, CM&AA, CMP

Good afternoon Madam Chair and Members of the Alaska House of Representatives. Thank you for the opportunity to speak before the Alaska House Health Education & Social Services Committee regarding the proposed House Bill 337: "*An act establishing the Alaska Health Care Commission and the Alaska Health Care Information Office; relating to healthcare planning and information; repealing the Certificate of Need program for certain healthcare facilities; and providing for and effective date.*[1]"

My name is Robert James Cimasi. I am President of Health Capital Consultants, a national healthcare economic and financial consulting firm located in St. Louis, MO. On August 16, 2001, I was appointed to serve on the Acute Care Focus Group of the Missouri Certificate of Need Technical Advisory Committee (CONTAC) for the Missouri Health Facilities Review Committee (MHFRC). Over the past few years my firm has conducted dedicated, focused research resulting in a comprehensive reference manual & sourcebook encompassing the statutory, regulatory, administrative, and legal aspects of Certificate of Need (CON) regulation from its inception in the late 1960's to the present. Elements of this research on CON were published in December 2005, as *"The U.S. Healthcare Certificate Of Need Sourcebook"* which summarizes numerous studies, monographs, and research reports regarding CON regulations, as well as, law review, bar journal articles, and in excess of 700 published legal cases related to CON. Attached to your handouts is a brief description of my professional qualifications.

Over the years, the scope of my professional activities including testimony in court, before legislative, and agency hearings, has required and permitted me and my firm to conduct extensive research and analysis in the areas of healthcare delivery, public health planning, healthcare economics, and market competition; as well as, other Certificate of Need (CON) related topics. Based on these activities and experiences, it is my informed view that this committee should vote to advance House Bill 337 (hereinafter referred to as the PROPOSED BILLS).

CON is a failed public health policy which is bad for Alaska citizens and patients for several key reasons. The following topics should be addressed:

1. **CON's History as A Failed Health Planning Policy;**
2. **The Effects of CON Repeal in Several States;**
3. **The Federal Trade Commission's Repeated Denunciation of CON;**
4. **CON Has Failed to Lower Healthcare Costs;**
5. **CON is Anti-competitive;**

[1] Health Care Plan/Commission/Facilities by Alaska House of Representatives , Alaska House of Representatives, January 2008. http://www.legis.state.ak.us/basis/get_bill.asp?bill=HB%20337&session=25 (2008)

6. **CON is a Barrier to Healthcare Innovation;**
7. **CON Reduces Access and Patient Choice; and,**
8. **CON Hasn't Improved Healthcare Quality.**

Testimony Related to Alaska House Bill 337: *An Act establishing the Alaska Health Care Commission and the Alaska Health Care Information Office; relating to healthcare planning and information; repealing the certificate of need program for certain healthcare facilities; and providing for an effective date"*

1. CON's History as Failed Health Planning Policy

CON legislation was put in place nationally as a result of a Federal mandate in 1974. Based on over three (3) decades of experience, it is now clear that the CON process does not offer the better, more efficient solution to reducing healthcare cost that its proponents have proudly proclaimed. As Duke Professor of Law Clark Havighurst concludes "*Protectionist regulation, long discredited in other areas, is particularly misguided in healthcare, where health insurance greatly increases the profitability of monopoly and imposes the resulting higher costs on unwilling premium payers. To use cross-subsidies to finance even worthy (let alone unworthy) health care projects is to put public burdens unfairly (regressively) on the backs of working Americans.*"[2]

By 1986, the federal government had shifted its attitude toward CON regulation. Over a decade later, the federal CON legislation previously passed in 1974 had failed. The National Health Planning Act was repealed due to *"mounting empirical evidence that certificate of need cost containment objectives were not being realized."*[3]

Instead, the application of CON regulation has only encouraged erroneous outcomes, to the detriment of Alaska's public interest, on the basis of insufficient valid data, flawed methodology, arbitrary and capricious standards, and the ambiguity of unrestricted agency discretion in an atmosphere of political influence. The Alaskan CON process' almost total lack of applicable, valid empirical data; the absence of generally accepted methodological standards of economic and financial analysis, and the lack of consideration of all required pertinent variables, are based on statutes and rules that are so fatally flawed and so clearly based on arbitrary and capricious standards as to be unreasonably burdensome on the citizens and patients of Alaska. Your passage of House Bill 337 would relieve this onerous situation.

2. Effects of CON Repeal

The Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine published a study of the certificate-of-need program in the state of Washington on January 8, 1999. The results of this study are published as the "*Effects of Certificate of Need and Its Possible Repeal*". This meta-study, one of the most comprehensive efforts recently conducted in the area of CON, *"examined the effects of CON and its possible repeal on the cost, quality, and availability of five health services – hospitals, ambulatory surgery, kidney treatment, home health, and hospice – as*

[2] "Monopoly Is Not The Answer," By Clark C. Havighurst, Health Affairs, August 9, 2005.
[3] *See* Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act's Certificate of Need a Market Correction?*, 22 Me. B.J. 156 (2007).

well as on charity care and health services in rural areas."[4] Results of this study were based on literature review, interviews, and information from healthcare providers and healthcare economic experts in the State, as well as an analysis of eight (8) states which completely or partially repealed their CON laws (i.e. Arizona, Indiana, Ohio, Pennsylvania, Tennessee, Texas, Utah, and Wisconsin).[5] The study found that CON *"has not controlled overall healthcare spending or hospital costs."* It also found *"conflicting or limited evidence about the effects of CON on the quality and availability of other healthcare services or about the effects of repealing CON."*[6]

The study does not predict the effects of CON repeal; however, the study reflected that CON has been shown to restrict the supply of some specific health services in some areas, and inferred that, perhaps as a result, supply surges occurred in some specific health services of some areas.[7] Some supply surges were experienced in psychiatric hospitals and nursing homes (Utah); nursing homes and open heart surgery (Arizona); home health (Tennessee); hospitals, ambulatory surgery centers, dialysis, and pediatric services (Ohio); hospitals and psychiatric hospitals (Wisconsin) and nursing homes and psychiatric hospitals (Texas) after the repeal of CON.[8] These finding were not consistent in every state that completely or partially repealed their CON laws that was included in the Washington study.

> *"Not all states experience surges after repeal. When surges do occur, they tend to moderate over time"...In addition, initial surges are sometimes followed by periods of shakeout and stabilization. Therefore, while short term supply increases do appear at times after CON repeal, such surges have been insufficiently studied to determine if there are any persistent effects on cost (or on other goals such as quality and access).*[9]

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[4] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. i.

[5] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. ii, 6.

[6] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. iii.

[7] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. 10.

[8] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. 13.

[9] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, pp. 11, 13.

A 1998 empirical study, which examined health spending between the late 1970's and 1993 and looked at spending prior to and directly after state CON laws were repealed, stated:

> *"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 non-hospital services)...We found that mature CON reduced hospital bed supply per capita population, but could detect no increase in bed supply following the removal of CON.*[10]

Further, the study authors found that established CON programs increased cost per adjusted patient day and also cost per admission.

According to a Conover and Sloan 1998 study, there was no empirical support that CON saved any money. Further, researchers concluded "There is no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations . . . CON regulations generally have no detectable effect on diffusion of various hospital-based technologies. It is doubtful that CON regulations have had much of an effect on quality of care, position of negative."[11] Experts have surmised that CON may increase the cost of health care. Administrative costs associated with state-level oversight and litigation expenses increase to the costs.[12] This is compounded by the problem that the CON approval process is highly technical in nature.

3. The Federal Trade Commission's Repeated Denunciation of CON;

3.1 FTC and DOJ Joint Hearings and Report on Healthcare Competition and CON

In November 2002, FTC Chairman, Timothy J. Muris, announced that the FTC would hold joint hearings with the DOJ on competition in healthcare in 2003.[13] On July 23, 2004, following the conclusion of the hearings lasting over six (6) months, the FTC and DOJ (agencies) issued a joint report on July 23, 2004, entitled "*Improving Health Care: A Dose of Competition*" in which the agencies recommended that states decrease barriers to entry into provider markets. The agencies encouraged states to reconsider whether CON programs "*best serve their citizens' health care*

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[10] "Does Removing Certification-of-Need and Regulations Lead to a Surge in Health Care Spending?" Conover, Christopher J., Sloan, Frank A., Journal of Health Politics, Policy and Law, vol. 23, no. 3, June 1998, p. 455

[11] Christopher J. Conover, Frank A. Sloan, *Does Removing Certificate of Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL. POL'YY & L. 455 (1998).

[12] *See* Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act's Certificate of Need a Market Correction?*, 22 Me. B.J. 156 (2007).

[13] "FTC Chairman Announces Public Hearings on Health Care and Competition Law and Policy to Begin in February 2003" Federal Trade Commission, www.ftc.gov/opa/2002/11/murishealthcare.htm, (Accessed Aug. 5, 2004).

needs".[14]

Following testimony at numerous hearings from industry representatives and legal, economic, and academic experts on the healthcare industry and health policy, the agencies concluded that the burdens placed on competition by CON programs "*generally outweigh*" its "*purported economic benefits*". *The agencies suggested that instead of reducing costs, there is evidence that CON programs actually drive up costs by "fostering anticompetitive barriers to entry".*[15]

The agencies expressed concern that CON programs raise healthcare costs because they appear to be used to shield healthcare providers from competition. The agencies expressed further concern that CON programs tend to prevent entry into the market by enterprises that may be able to provide higher quality care, and the report contended that CON programs may delay the introduction of new technology. In support of their conclusions, the agencies relied upon empirical studies that showed CON programs generally failed to control costs and actually appear to result in higher healthcare costs.[16]

Subsequent to the FTC's July 23, 2004 report, on May 24, 2005 , the FTC delivered a statement before the SubCommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, the agency stated , " *vigorous competition can have important benefits in the hospital arena, just as in the multitude of markets in the U.S. economy that rely on competition to maximize the welfare of consumers. Competitive pressures can lead hospitals to lower costs, improve quality and compete more efficiently. Competitive pressures also may spur new types of competition. In hospital markets, some new entrants specialize and prove only a limited portion of the in-patient and out-patient services that general hospitals tend to provide.*"[17] Specifically, the FTC testimony emphasized that, "*Overall, testimony at the FTC/DOJ Hearings identified a number of benefits that SSHs [single specialty hospitals] may offer to consumers, with no significant controversy about the potential for SSHs to provide those benefits. Rather, as discussed in more detail below, debate about SSHs generally centered on how they may affect the functioning of general hospitals.* "[18] Ultimately, the FTC testimony related to the efficacy of CON concluded that,

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[14] "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004, Executive Summary, p. 22.

[15] "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004, ch. 8, pp. 1-2.

[16] "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004, ch. 8, p. 4.

[17] Prepared Statement of the Federal Trade Commission Before the SubCommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, May 24, 2005, p. 3.

[18] Prepared Statement of the Federal Trade Commission Before the SubCommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, May 24, 2005, p. 8.

> *"The Commission believes that CON programs generally are not successful in containing health care costs, and that they can pose anticompetitive risk. As noted above, CON programs risk entrenching oligopolists and eroding consumer welfare. The aim of controlling costs is laudable, but there appear to be other, more effective means of achieving this goal that do not pose anticompetitive risks. Indeed, competition itself is often the most effective method of controlling costs. A similar analysis applies to the use of CON programs to enhance health care quality and access."*[19]

These Federal findings, by the FTC and DOJ, are only one of the significant pronouncements in the last several years that support the rational justification to eliminate CON and support a level playing field for providers in fostering *"a dose of"* market competition in healthcare.

3.2 Previous FTC Studies of CON

The FTC's unfavorable review of CON as a failed health policy planning mechanism is not a new event. Beginning in the late 1980s, the FTC issued several studies on CON and stated that, *"Market forces generally allocate society's resources far better than decisions of government planners."*[20]

3.3 The FTC's Recommendations That States Repeal CON

The FTC has consistently recommended that the states remove their CON regulations. In a 1987 letter to Virginia officials they stated, *"Any potential benefits of CON regulation are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, CON regulation is likely to harm consumers on balance by increasing the price, and decreasing the quality, of health services in Virginia."*[21] The FTC has issued similar statements before numerous states considering the repeal of CON laws.

4. CON Has Failed To Lower Healthcare Costs

After nearly thirty (30) years of study, the preponderance of healthcare economic analysis has clearly indicated that CON laws have failed to achieve their stated objectives. In an article reviewing CON laws and their application to modern markets, Patrick J. McGinley, Esq. wrote, *"In searching the scholarly journals, one cannot find a single article that asserts that CON laws*

[19] Prepared Statement of the Federal Trade Commission Before the Subcommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, May 24, 2005, p. 18.
[20] Press Release from the Federal Trade Commission, Aug. 10, 1987
[21] Press Release from the Federal Trade Commission, Aug. 10, 1987

succeed in lowering healthcare costs."[22]

In fact, a 2003 study headed by David C. Grabowski entitled *"The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures"* found no significant increase in either nursing home or long-term care Medicaid expenditures in states that repealed their CON and moratorium laws.[23]

This confirmed the findings of an earlier 1998 study by Christopher J. Conover and Frank A. Sloan that mature CON laws resulted in a *"two percent (2%) reduction in bed supply but higher cost per-day and per admission, along with higher hospital profits."*[24]

Additionally, a recent report commissioned by, and presented to the Georgia CON Commission by William S. Custer, Ph.D., entitled, *"Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program,"* dispels many of the continuing myths propounded by CON advocates which assert that CON controls healthcare costs. Dr. Custer described his findings related to the overall strategy of CON regulation as the management of the allocation of health care resources and prevention of the duplication of services by creating artificial barriers to market entry, resulting in monopoly of players already present in the market.[25] Further, in response to the Georgia Commission's request for Dr. Custer to study the efficacy of CON, Dr. Custer concluded that, contrary to the purpose of CON, basic economic theory suggests that monopolies generally have higher process and lower quality than firms in more competitive markets.[26]

Although one of the original purposes of CON was to restrict supply of hospital beds and services, the authors concluded that there does not seem to be a statistically significant correlation between a lower number of hospitals or hospital bed supply and the presence of CON regulation in the acute setting.[27] Of the states studied, while Georgia experienced the most rapid growth in the number of ambulatory surgery centers, it is important to highlight that the study

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[22] "Beyond Health Care Reform: Reconsidering Certificate of Need Laws In a Managed Care Competition System", McGinley, PJ., Florida State University Law Review, 1995.
[23] "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures", Grabowski, David C., Ohsfeldt, Robert L., Morrisey, Michael A., Inquiry-Excellus Health Plan, vol. 40, no. 2, Summer 2003, p. 147.
[24] "Does Removing Certification-of-Need and Regulations Lead to a Surge in Health Care Spending?" Conover, Christopher J., Sloan, Frank A., Journal of Health Politics, Policy and Law, vol. 23, no. 3, June 1998, pp. 463, 466.
[25] "Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program," By William S. Custer, Ph.D. et al, October 2006, p.5.
[26] "Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program," By William S. Custer, Ph.D. et al, October 2006, p.5.
[27] "Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program," By William S. Custer, Ph.D. et al, October 2006, p.7.

found that there was "***not a statistically significant relationship between CON rigor and the number or growth of ASCs.***"[emphasis added].[28]

Recently, the proponents of CON have suggested that CON is necessary to protect charity care provided by community hospitals. However, this assertion has been strongly rebuked. Recently, a working paper prepared by the FTC concluded that, "*Most noticeable in all of the results is the lack of any statistically significant evidence for the cross-subsidization hypothesis. The data provides no statistically significant evidence that increased competition leads to reductions in charity care. The claim that hospitals will use market power to increase services to the poor is largely unsupported by this data.*"[29]

As stated by Clark C. Havighurst, a William Neal Reynolds Professor Emeritus of Law at Duke University School of Law, *"The huge enterprises that U.S. hospitals have become are largely unaccountable for the amounts of revenue they raise or the uses to which they put that money. Indeed, they are major contributors to ever-rising healthcare costs. Using CON regulation to maintain their ability to extract resources from the economy only to pour them back into more health care would keep costs under control. Competition is the best way both to limit dominant hospitals' claims on gross domestic product (GDP) and to restore voters and their representatives the power to decide just what extras are worth paying for."*[30]

Aside from its ineffectiveness in reducing costs and its inability to promote charity care, CON itself incurs large administrative and indirect costs as an added burden on available healthcare funding. As Christopher J Conover, an assistant research professor with the Center for Health Policy, Law and Management in the Terry Sanford Institute of Public Policy at Duke University, recently stated, "*There is a significant amount of literature on the benefits and costs of regulation in the U.S. economy, with the first efforts to estimate the overall impact dating back to the mid-1970s. From this work it is known that regulations impose a considerable burden on U.S. businesses and consumers: the impact of regulation on the overall economy will approach $1 trillion in 2004.*" Specifically, Conover found that, CON regulations had a net cost of approximately $110 million, with no value to consumers. "*The most recent studies that use the most credible statistical methods and most recent data find no impact of CON regulation on health spending (and concomitantly no increase in health spending among states that have elected to drop CON regulation), so zero was used as the expected value.*"[31] The cost of attorneys, consultants, lobbyists and internal staff to healthcare organizations for CON

[28] "Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program," By William S. Custer, Ph.D. et al, October 2006, p.8.
[29] "Hospital Competition and Charity Care," Working Paper No. 285By Christopher Garmon, Bureau of Economics Federal Trade Commission, October 2006, p.18.
[30] "Monopoly Is Not The Answer," By Clark C. Havighurst, Health Affairs, August 9, 2005.
[31] "Health Care Regulation A $169 Billion Hidden Tax," By Christopher J. Conover, Policy Analysis, No. 527, CATO Institute, October 4, 2004, pp.2, 8.

applications is considerable. Litigation and lobbying on both sides of the CON debate are other significant costs.

CON was originally conceived in the old payment structure plan of fee for service. With the advent of managed-care and the sea change it has brought to healthcare, CON is more useless now than ever. CON has devised what economist call the "Roemer Effect" which essentially means if there is a hospital bed to be filled, doctors will find a way to do so to increase their revenue. Yet managed care, with capitation payment schemes, has eliminated the "Roemer Effect" and the incentive to provide unnecessary or "duplicative" services. Physicians and hospitals are under pressure to constrain and control their expenses, not balloon them.[32]

5. CON is Anti-competitive

Competition creates choices for consumers and raises quality standards as providers compete for patient loyalty. A 1993 study found that hospitals in more competitive markets had average costs below those of less competitive markets.[33] According to Professor Carolyn Madden, "*[T]here is ... agreement across all perspectives of [health economics theory] on one issue: the negative consequences of too much concentration of economic power.*"[34]

The evidence presented by Ellen S. Campbell and Gary M. Fournier in their 1993 study entitled, *"Certificate-of-Need Deregulation and Indigent Hospital Care,"* commented on CON's anticompetitive effect, in suggesting that overall CON policy is absent of a *"clear, economic, and legal standard to distinguish between an action to deny an applicant in order to prevent investments that would raise costs by unnecessary duplication, and actions motivated by the anticompetitive effect of such denial...[T]he trouble is that agency decisions can often accomplish the latter while claiming the former."*[35]

As Duke Professor of Law Clark Havighurst concludes, *"But CON regulation was itself not clearly intended to suppress competition that is inconvenient for certain hospitals. Ostensibly, at least, the original rationale for enacting CON laws in the regulation-ridden 1970s was policymakers' belief that market forces could not be trusted to defer overinvestment in health facilities. Since that time, cost reimbursement have been replaced by prospective payment (even for capital expenditures), removing a major cause of the problem that first occasioned CON regulation. In addition, private health plans have developed the ability to steer patients to cooperative, low-cost providers, thereby signifying a "need" for the latter's facilities and*

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[32] *See* Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act's Certificate of Need a Market Correction?*, 22 Me. B.J. 156 (2007).

[33] "California Providers Adjust To Increasing Price Controls", Zwanziger J, Melnick G, Bamezai A., Health Policy Reform: Competition and Controls, AEI Press, 1993, pp 241-58.

[34] Madden CW. "Excess capacity: markets, regulation, and values." Health Services Research. February, 1999.

[35] "Certificate-of-Need Deregulation and Indigent Hospital Care", Campbell, Ellen S., Fournier, Gary M., Journal of Health Politics, Policy and Law, vol. 18, no. 4, Winter 1993, pp. 922-923.

services and belying the old notion that supply can create its own demand. Thus, whatever, might have been the case in the earlier era, it is far from obvious today that CON regulation is needed to avoid excess capacity."[36]

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

6. CON is a Barrier to Healthcare Innovation

Because CON acts as a barrier to entry for new market entrant competitors, it slows the introduction of new healthcare facilities, equipment, and services and thus acts as a barrier to healthcare innovation. Famed economist Michael Porter wrote in the Harvard Business Review:

> *"In industry after industry, the underlying dynamic is the same: competition compels companies to deliver increasing value to customers. The fundamental driver of this continuous quality improvement and cost reduction is innovation. Without incentives to sustain innovation in healthcare, short-term cost savings will soon be overwhelmed by the desire to widen access, the growing health needs of an aging population, and the unwillingness of Americans to settle for anything less than the best treatments available. Inevitably, the failure to promote innovation will lead to lower quality or more rationing of care – two equally undesirable results."*[37]

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

7. CON Reduces Access and Patient Choice

The fundamental and simplistic, yet flawed, idea of CON was straightforward: lower costs by "reducing duplication". However both competition and patient choice, by definition, require "duplication" of providers. Denial of patient choice in Alaska is tightly correlated with the barrier to entry posed by CON. New medical provider entrants, no matter how efficiently and

[36] "Monopoly Is Not The Answer," By Clark C. Havighurst, Health Affairs, August 9, 2005.
[37] "Making competition in health care work." By Michael Porter, et al. Harvard Business Review, July/Aug. 1994, p. 131.

creatively they might contribute to higher quality, more beneficial outcomes, and lower overall healthcare costs, face substantial opposition by these established oligopoly interests, who, historically, have actively strived to limit competition with the resulting impact of denying patient choice for Alaskans and their families.

Excess capacity is a value-laden term, not an absolute standard. In a February 1999 article published in Health Services Research, Professor Carolyn Madden summarized a number of studies of excess capacity saying, *"Without a clear statement of this standard [e.g., the correct number of hospital beds], we cannot determine what constitutes too many. The research literature provides no clear statement."*[38]

Access issues are especially important in rural areas where patients must travel long distances and have little choice of provider. Access is closely linked to patient choice. When choice is diminished, decisions about access, quality, and beneficial outcomes are made in isolation by healthcare businesses. In the absence of healthy competition, they are free to ignore patient needs and demands.

Under CON laws, patients are *de facto* limited to accept the services that existing providers wish to offer them when making major healthcare decisions for themselves and their families because their geographic region may be determined by CON administrators to lack a sufficient utilization ratio to allow alternative market entrants.

8. CON Hasn't Improved Healthcare Quality

CON proponents, faced with irrefutable empirical data and evidence that CON has utterly failed, now have attempted to shift their ever-changing arguments to a new focus, that CON protects quality. They claim that by limiting the number of locations for highly technical surgeries and procedures, that each location and surgeon gains a greater level of experience with these procedures, which results in better quality outcomes. Part of this argument by CON proponents is based on the disingenuous quoting of research from *"The Dartmouth Atlas of Healthcare"* which does not support this assertion. Further, there have been a number of studies which contradict these assertions.[39] An article, in the March 2003 issue of Health Affairs entitled, *"Why Competition Law Matters To Health Care Quality"* once again refutes the validity of these CON proponents latest desperate move to maintain this failed policy.[40]

Healthcare economists know that in the absence of sustained competition, large provider systems have little or no incentive to offer the highest quality at the lowest price. Effective health policy

[38] Madden CW. "Excess capacity: markets, regulation, and values." Health Services Research. February, 1999.
[39] "Is volume related to outcome in health care? A Systematic review and methodologic critique of the literature", Annals of Internal Medicine, Sept. 17, 2002, p. 511.
[40] "Why competition law matters to health care quality", Health Affairs, Vol. 22, no. 2 (March/April 2003), p. 31.

planning should let the quality of services and beneficial outcomes define the level of competition, not the present failed system of CON review.

CON essentially serves as an ineffective means for rationing healthcare access to facilities, equipment (often innovation and technology) and services, thereby acting to ration care. Expanded access to healthcare and innovative new technologies has transformed modern lifestyles, improved the quality of life and life expectancy in the U.S., and contributed to increased productivity in the U.S. workforce. A CON regulatory system that has demonstrated that it cannot control costs, even by irrationally rationing healthcare, has now, in desperation, turned to the "Quality and Safety" issues as the "refuge of a scoundrel."

9. Summary

CON, although began with the best intentions, has failed in its goals of reducing costs, improving access and quality of care, and preventing duplication of medical services.[41]

In my view, the Alaska House of Representatives Health Education and Social Services Committee has an opportunity on behalf of the citizens of the State of Alaska to thoroughly investigate and eliminate a clearly failed health planning policy, which has undoubtedly cost the taxpayers of Alaska more than had CON never existed and impeded healthcare access for Alaska patients and their families. The Federal government, who first imposed CON on all the states, learned this early on after the change from a "cost plus" to a "prospective payment system" and has repeatedly denounced this failed health planning policy. CON has not achieved its stated purpose of reducing overall healthcare costs, as demonstrated by the preponderance of empirical evidence. Further, CON has caused severe regulatory interference in the healthcare market economy of Alaska in an uninformed, irrational, unfair and capricious manner.

I close by making a request of this committee and a commitment. The request is to urgently ask you to advance the efforts to repeal CON in Alaska. I commit to you that I will make available to you whatever related performance data, information and research related to the history of CON and its implementation in the State of Alaska as you may request. I urge you to get informed on this issue and offer to make myself and my staff available to any of you that may wish additional information in support of my position. I remain confident that once you have the facts, CON regulation in Alaska will be repealed.

Respectfully Submitted,

[41] *See* Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act's Certificate of Need a Market Correction?*, 22 Me. B.J. 156 (2007).

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Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, the Accredited Senior Appraiser (ASA) designation in Business Valuation, as well as, the Certified Business Appraiser (CBA), Accredited Valuation Analyst (AVA), the Certified Merger & Acquisition Advisors (CM&AA), and the Certified Medical Planner (CMP) professional designations (see *Professional Designations* section below). He is a nationally known speaker on healthcare industry topics, who has served as conference faculty or presenter for such organizations as the American Society of Appraisers (ASA), the Institute of Business Appraisers (IBA), the American Institute of Certified Public Accountants (AICPA), the National Association of Certified Valuation Analysts (NACVA), the American College of Healthcare Executives (ACHE), the National Society of Certified Healthcare Business Consultants(NSCHBC), the Academy Health, Healthcare Financial Management Association (HFMA), the American Association of Ambulatory Surgery Centers (AAASC),Physician Hospitals of America (PHA) f/k/a American Surgical Hospital Association (ASHA), National Litigation Support Services Association (NLSSA), as well as many other national and state healthcare industry associations and professional societies, trade groups, companies and organizations. He has been certified and has served as an expert witness on cases in numerous states, and has provided testimony before federal and state legislative committees. In 2006, Mr. Cimasi was honored with the prestigious *Shannon Pratt Award in Business Valuation* conferred by the Institute of Business Appraisers and was recently elevated to its College of Fellows in 2007. Mr. Cimasi is the author of *A Guide To Consulting Services for Emerging Healthcare Organizations* (John Wiley & Sons, 1999), *The Valuation of Healthcare Entities in a Changing Regulatory and Reimbursement Environment* (IBA Course 1011 text - 1999), and the author of *An Exciting Insight Into the Health Care Industry and Medical Practice Valuation* (AICPA course text 1997, rev. 2006.) He has authored chapters on healthcare valuation in The Handbook of Business Valuation (John Wiley & Sons), *Valuing Professional Practices and Licenses: A Guide for the Matrimonial Practitioner, 3rd ed., 1999* (Aspen Law & Business), and *Valuing Specific Assets in Divorce* (Aspen Law & Business) and has been a contributor to The Guide to Business Valuations (Practitioners Publishing Company), *Physician's Managed Care Success Manual: Strategic Options, Alliances, and Contracting Issues* (Mosby), and numerous other chapters. He has written published articles in peer review journals, frequently presented research papers and case studies before national conferences, and is often quoted by healthcare industry professional publications and the general media. Mr. Cimasi's latest book, *The U.S. Healthcare Certificate of Need Sourcebook*, was published in 2005 by Beard Books.

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Competition in Healthcare and Certificates of Need

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January 31, 2008[1]

Good afternoon. I appreciate the invitation to the Antitrust Division of the U.S. Department of Justice to share our views on the impact of Certificate of Need ("CON") laws on healthcare markets.

My name is Joseph Miller. I am the Assistant Chief of the Litigation I Section of the Antitrust Division. The Litigation I Section enforces the antitrust laws in a wide variety of industries, including healthcare markets. Our attorneys confer closely with a large team of economists holding doctorates in the study of markets and their performance, including a number with specialization in the performance of healthcare markets. We also confer closely with the attorneys and economists at the Federal Trade Commission, who have dedicated time to the study of healthcare markets.

The Antitrust Division and the FTC have investigated and litigated antitrust cases in markets across the country involving hospitals, physicians, ambulatory surgery centers, stand-alone radiology programs, medical equipment, pharmaceuticals and other healthcare products. Through that work we have developed a substantial understanding of the competitive forces that drive innovation in and contain the costs of healthcare. We regularly issue informal advisory letters on the application of the antitrust laws to healthcare markets, and periodically issue reports and general guidance to the healthcare community. For example, in 2003, we conducted 27 days of hearings on competition and policy concerns in the healthcare industry, heard from approximately 250 panelists, elicited 62 written submissions, and generated almost 6,000 pages of transcripts.[2] As a result of that effort, we published an extensive report, entitled *Improving Health Care: A Dose of Competition*, in July 2004.

I. Scope of Remarks

The Antitrust Division's experience and expertise has taught us that Certificate of Need laws pose a substantial threat to the efficient performance of healthcare markets. By their very nature, CON laws create barriers to entry and expansion and thus restrict free and open

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[1] This paper draws significantly from testimony delivered on behalf of the Antitrust Division to the General Assembly and Senate of the State of Georgia on February 23, 2007.

[2] This extensive hearing record is largely available at http://www.ftc.gov/bc/healthcare/research/healthcarehearing.htm.

competition. They undercut consumer choice, weaken markets' ability to contain healthcare costs, and stifle innovation.

We have examined historical and current arguments for CON laws, and conclude that such arguments provide no economic justification for depriving consumers' of the benefits of free markets. To the extent that CONs are used to further non-economic goals, they impose substantial costs. Such goals, purportedly furthered through CON laws, can be more efficiently achieved through other mechanisms. We hope you will carefully consider the substantial costs that CON laws impose on consumers as you evaluate whether to eliminate those laws in Alaska.

I do not testify today to discuss the details of the legislation you are considering. I am, however, generally familiar with the issues before you and recognize them as issues that CON laws present in other states and other markets. My remarks, accordingly, will focus on the impact of and justifications for CON laws generally.

It is not the Antitrust Division's intent to "favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire Rather, [our] goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices . . ."[3] Our overall mission is to preserve and promote economic competition rather than to preserve any particular marketplace rival or group of rivals.

II. Importance of Competition and the Harm Caused by Regulatory Barriers to Entry

A. The Benefits of Competition in Healthcare

Our concerns about the harm from CON laws are informed by one fundamental principle: market forces improve the quality and lower the costs of healthcare services. They drive innovation and ultimately lead to the delivery of better healthcare. Government intervention can undermine market forces to the detriment of healthcare consumers.

In our antitrust investigations we often hear the argument that healthcare is "different" and therefore competition principles do not apply to the provision of healthcare services. The proposition that competition cannot work in healthcare is simply not true. Engineers and lawyers have made similar arguments that competition does not work in their industries and, in fact undermined other social goods advanced by their professions. Such arguments have been rejected by the courts, and private restraints on competition have long been condemned.[4] Indeed, at least since the Supreme Court's seminal 1943 decision in a case brought by the Department of Justice against the American Medical Association, competition has played a critical role in

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[3] Statements of Antitrust Enforcement Policy in Health Care, August 1996, Introduction, pg. 3 (available at: http://www.usdoj.gov/atr/public/guidelines/1791.htm).

[4] *F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990); *National Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978).

shaping the delivery of healthcare in this country.[5] The Antitrust Division and the Federal Trade Commission have worked diligently to make sure that private barriers to that competition do not arise.

During our extensive healthcare hearings in 2003, we obtained substantial evidence generally about the role of competition in our healthcare delivery system and reached the conclusion that vigorous competition among healthcare providers "promotes the delivery of high-quality, cost-effective healthcare." Specifically, competition results in lower prices and broader access to health care and health insurance, while non-price competition can promote higher quality.[6]

This finding is not new. We saw in the 1990s the growth of managed care and the impact it had on the cost and availability of insurance. Competition among and between hospitals and physicians intensified with the development of managed care organizations. In addition to putting pressure on costs, managed care plans have pressured providers to use shorter hospital stays and to offer alternative outpatient treatments. This evolution in health care purchasing led to lower costs and increased choice without sacrificing quality. Moreover, lower costs and improved efficiency made health insurance more affordable and available.

Competition also helped bring to consumers important innovations in healthcare technology. For example, health plan demand for lower costs and "patient demand for a non-institutional, friendly, convenient setting for their surgical care" drove the growth of Ambulatory Surgery Centers (ASCs).[7] Ambulatory surgery centers offered patients more "convenient locations, shorter wait time, and lower coinsurance than a hospital department."[8] Important to the success of these competitive forces in improving the delivery of care to consumers was the availability of technological advances, such as endoscopic surgery and advanced anesthetic agents.[9] Thus, competition harnessed this new technology and brought it to consumers in the lower cost, more convenient setting of ambulatory surgery centers. The impact on traditional general acute care hospitals led to those hospitals responding to the competition by delivering more care, in a better manner, in an outpatient setting, both at their own campuses and at ambulatory surgery centers in which they invested.

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[5] *American Medical Association v. U.S.*, 317 U.S. 519, 529 (1943).

[6] *Improving Health Care: A Dose of Competition*, ch. 3 § VIII and Executive Summary at 4 (July 2004) available at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf. ("*A Dose of Competition*").

[7] Id., Ch. 3 at 25.

[8] Medicare Payment Advisory Commitions (MedPAC), Report to the Congress: Medicare Payment Policy § 2F, at 140 (2003), available at http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf.

[9] A Dose of Competition, at ch. 3 at 24.

Th' type of competitive success story has occurred again and again in healthcare in the area of pharmaceuticals, urgent care centers, and elective surgeries such as Lasik procedures, to name just a few. Without private or governmental impediments to their performance, we can expect healthcare markets to continue to deliver these benefits.

B. CON Laws Create Barriers to Beneficial Competition

CON laws are a classic government-erected barrier to entry, and by their nature are an impediment to the proper functioning of the market process. Accordingly, in *A Dose of Competition*, the Federal Trade Commission and we urged the states to rethink their CON laws.[10]

1. Original Cost-Control Reasons For CON Laws No Longer Apply

We made that recommendation in part because the original reason for the adoption of CON laws is no longer valid. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974, which offered incentives for states to implement CON programs. At the time, the federal government and private insurance reimbursed healthcare charges predominantly on a "cost-plus" basis, which provided incentives for over-investment. The hope was that CON laws would provide a counterweight against that skewed incentive.

In considering this historical justification for CON laws, we need to keep clear that a number of other arguments made today in support of CON laws were not part of the rationale for their original adoption –

* CON laws were not adopted as a means of cross-subsidizing care;
* CON laws were not adopted in order to have centralized planning of the location and nature of healthcare facilities; and,
* CON laws were not adopted to protect the health and safety of the population from poor quality medicine.

Instead, CON laws were adopted because excessive capital investments, spurred by the then-current cost-plus method of reimbursement, were driving up healthcare costs. There was concern that, because patients are usually not price-sensitive, providers engaged in a "medical arms race" by unnecessarily expanding their services to offer the perceived highest quality services.[11]

CON laws appear to have failed in their intended purpose of containing costs. Several studies have examined the effectiveness of CONs in controlling costs. The empirical evidence

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[10] *A Dose of Competition*, Executive Summary at 22.

[11] *A Dose of Competition*, Ch. 8, pg. 1-2.

on the economic effects of CON programs has demonstrated near-universal agreement among health economists that CON laws were unsuccessful in containing healthcare costs.[12]

In addition to the fact that CON laws have been ineffective in serving their original purpose, CON laws should be reexamined because the reimbursement methodologies that may in theory have justified them initially have changed significantly since the 1970s. The federal government no longer reimburses on a cost-plus basis. In 1986, Congress repealed the National Health Planning and Resources Development Act of 1974. Additionally, health plans and other purchasers routinely bargain with healthcare providers over prices. Essentially, government regulations have changed in a way that eliminates the original justification for CON programs.[13]

2. Protecting Revenues of Incumbents Does Not Justify CON Laws

Incumbent hospitals often argue that they should be protected against additional competition so that they can continue to cross-subsidize care provided to uninsured or under-insured patients. Under this rationale, CON laws would impede the entry of such healthcare providers as independent ambulatory surgery centers, free-standing radiology or radiation-therapy providers, single- or multi-specialty physician-owned hospitals, because if these new competitors were to enter the marketplace, community hospitals could not continue to exploit their existing market power over consumers. Put another way, without CON laws, we would see new, higher-quality, low cost providers in the marketplace, which would put competitive pressure on incumbent providers, and deprive them of revenues they could put to a charitable use.[14]

We fully appreciate the laudatory goal of providing sufficient funding for community hospitals so that these hospitals can provide healthcare services to those who cannot afford them and for whom government payments are either unavailable or too little to cover the cost of care. But, we also want to make clear that the use of government barriers to entry to fund indigent care has costs. There are more efficient ways to accomplish this goal without incurring the costs of impeding the proper functioning of health care markets. Essentially, by protecting incumbent hospitals from competition, CON laws allow dominant hospitals to tax consumers through the exercise of market power in order to pursue the charitable goal of providing care to other, less fortunate consumers. In using that funding mechanism, however, the CON laws may do more harm than good.

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[12] David S. Salkever, Regulation of Prices and Investment in Hospital in the United States, in 1B Handbook of Health Economics, 1489-90 (A.J. Culyer & J.P. Newhouse eds., 2000) ("there is little evidence that [1970's era] investment controls reduced the rate of cost growth.")

[13] *A Dose of Competition* at pg. 1-6.

[14] Note the irony of this argument: What started as laws intended to control costs have become laws intended to inflate costs. Proponents of CON laws now would use these barriers to entry to stifle competition, protect incumbent market power, frustrate consumer choice, and keep prices and profits high.

First, CON laws harm the consumers who would have chosen alternative, lower priced, higher quality, or more convenient sources of care.

Second, CON laws impose that cost without any clear evidence that other desired social goals are advanced. The evidence to date indicates that new competition does not undercut community hospitals' ability to fulfill charitable missions. Rec ntly the federal government studied just this issue in connection with the emergence of single-specialty hospitals around the country. The study found that, for several reasons, specialty hospitals did not undercut the financial viability of rival community hospitals.[15] One substantial reason for this was that specialty hospitals generally locate in areas that have above average population growth. Thus, they are competing for a new and growing patient population, not just siphoning off the existing customer base of the community hospitals.

Third, new competition can force community hospitals to improve their performance. In studying the effect of single-specialty hospitals, MedPAC found that the community hospitals responded to the competition by improving efficiency, adjusting their pricing, and expanding profitable lines of business.[16] Community hospitals encouraged physicians to perform procedures on the hospital campus by developing centers of excellence and building physician offices on campus.[17] Overall, community hospitals affected by specialty hospital entry maintained profit margins in line with national averages. Rather than undercutting community hospitals, new entry drives them to do a better job. Thus, in addition to the harm to the consumers who would have chosen the new healthcare provider, CON laws harm society in general by depriving it of the increased efficiency that competition would have brought to the health care market.

3. CON Laws Impose Other Costs And May Facilitate Anti-Competitive Behavior

CON laws appear to raise a particularly substantial barrier to entry and expansion of competitors because they create an opportunity for existing competitors to exploit procedural

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[15] Report to the Congress: Physician-Owned Specialty Hospitals Revisited, pg. 21-25 (August 2006), available at http://www.medpac.gov/publications/congressional_reports/Aug06_specialtyhospital_mandated_report.pdf. ("MedPAC 2006 Report") (concluding that physician-owned specialty hospitals admit a lower proportion of Medicaid patients)

[16] Other studies have found that the presence of for-profit competitors leads to increased efficiency at nonprofit hospitals. Kessler, D. and McClellan M., "The Effects of Hospital Ownership on Medical Productivity," RAND Journal of Economics 33 (3), 488-506 (2002).

[17] Greenwald, L. et al., "Specialty Versus Community Hospitals: Referrals, Quality, and Community Benefits," *Health Affairs* 25, no. 1 (2006): 116-117. *See also* Stensland J. and Winter A., "Do Physician-Owned Cardiac Hospitals Increase Utilization?" *Health Affairs* 25, no. 1 (2006): 128 (some community hospitals have responded to the presence of specialty hospitals by recruiting physicians and adding new cardiac catheterization labs).

opportunities to thwart or delay new competition. Such behavior, commonly called "rent seeking" conduct, is a well-recognized consequence of regulatory intervention in the market.[18] Essentially, an existing competitor uses the hearing and appeals process to cause substantial delays, leading both the existing competitor and the new entrant to divert significant funds away from delivering healthcare and to spend them on legal fees, consulting fees, and lobbying efforts. Moreover, much of this conduct, even if exclusionary and anticompetitive, is unlikely to be subject to legal challenge as a violation of the antitrust laws because it involves petitioning of the state government by the existing competitor.[19] Indeed, during our hearings, we received evidence of the widespread recognition that existing competitors use the CON process "to forestall competitors from entering an incumbent's market."[20]

We have found that existing competitors, at times with the encouragement or acquiescence of state officials, go further and enter into agreements not required by the CON laws but nonetheless facilitated by them. Two examples arise from West Virginia, and a third comes from Vermont.

In the first West Virginia case, we found that a Charleston, West Virginia hospital used the threat of objection during the CON process, and the potential ensuing delay and cost, to induce a hospital seeking a certificate of need for an open heart surgery program not to apply for it at the location that would have well served Charleston consumers and provided greater competition for their business.[21] Instead, the Charleston hospital successfully prevented the possibility of this competing open heart program. The state authorities never had the opportunity to decide whether under the CON laws that second program would have been approved because of the unlawful agreement among the hospitals.

In the second West Virginia case, two closely competing hospitals decided to allocate healthcare services between themselves.[22] The informal urging of state CON officials led them to agree unlawfully that only the one hospital would apply for an open heart program and only the other would apply to provide cancer services. Again, the state took no official action and consumers were deprived of the potential competition between these hospitals.

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[18] Joskow, Paul and Rose, Nancy, "The Effects of Economic Regulation." *Handbook of Industrial Organization, vol. 2*, Schmalensee and Willig, ed. Amsterdam: North-Holland, 1989.

[19] *Eastern Rail. Pres. Conf. v. Noerr Motor Frgt., Inc.*, 365 U.S. 127 (1961).

[20] *A Dose of Competition*, Executive Summary at 22.

[21] *U.S. v. Charleston Area Medical Center, Inc.*, Civil Action 2:06 -0091 (S.D.W.Va. 2006) (available at: http://www.usdoj.gov/atr/cases/f214400/214477.htm).

[22] *U.S. v. Bluefield Regional Medical Center, Inc.*, 2005-2 Trade Cases ¶ 74,916 (S.D. W.Va. 2005).

A third example comes from the State of Vermont. There, home health agencies entered into territorial market allocations, again under cover of the state regulatory program, to give each other exclusive geographic markets.[23] That state's CON laws prevented competitive entry, which normally might have disciplined such cartel behavior. We found that Vermont consumers were paying higher prices than were consumers in states where home health agencies competed against each other.

We have learned from these matters and others that CON laws have the potential to impede competition in ways well beyond what is intended by their supporters.

III. Conclusion

My remarks are intended to convey to you our belief that CON laws impose substantial costs on consumers and healthcare markets. In light of these costs, the Antitrust Division believes that Alaska should carefully consider whether on balance its CON laws do more harm than good. Let me close by encouraging you not to accept without careful scrutiny claims that elimination of CON laws will visit significant harm on your state.

Thank you again for the opportunity to discuss our views on how CON laws affect competition and consumers in healthcare. I would be happy to take your questions.

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[23] Department of Justice Statement on the Closing of the Vermont Home Health Investigation, (Nov. 23, 2005) (available at: http://www.usdoj.gov/atr/public/press_releases/2005/213248.htm).

I. Introduction

KMD Services & Consulting was contracted by the State of Alaska, Department of Health and Human Services (DHSS) to facilitate the Certificate of Need Negotiated Rulemaking Committee. Kevin Dee was lead facilitator. This was the first ever attempt to bring various vested parties together to attempt to reach consensus on the "Certificate of Need" (CON) process, rules and regulations.

The Committee members were selected through a voluntary process by DHSS and five days of meetings to review and make recommendations were held. The committee was asked to look at anything and everything related to the CON process including statutes, regulations and processes. The dates of the meetings were; October 29-30, 2007, November 13-14, 2007 & November 20, 2007. There were between 19 – 21 committee members present at all meetings. Committee members were comprised of Doctors and Hospital administrators and one representative from DHSS . The actual participants of the committee varied from session to session due to substitutions. The committee members and their attendance are listed below.

Rep Rogers: 8/22 were Hospital

Certificate of Need Negotiated Regulation Committee Members

Present at meeting = X , Absent = A, Substitute = Sub

1	[illegible]	[illegible] Health of Anchorage	X	[illegible]	[illegible]	Sub	X	[illegible]
2	Imaging	Jeff Kinion, CEO Alaska Open Imaging Center Wasilla	X	X	X	X	X	
3	Imaging	[illegible] Bridges, MD Alaska Diagnostic Imaging, LLC Fairbanks	X	X	X	X in am only pm = Sub	X	Kim Black sub in afternoon
4	Imaging	Chakri Inampudi, MD Alaska Radiology Associates Anchorage	X	X	X*	X	X	*Left prior to meeting end on 11/13
5	Imaging	Bradley K. Cruz, M.D. Alaska Imaging Associates, LLC Anchorage	X	X	X	X	Sub	Lester Lewis, MD

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Rep Rozes 8/7-2 surve Hospital

Certificate of Need Negotiated Regulation Committee Members

Present at meeting = X , Absent = A, Substitute = Sub

1	Imaging	Ward Hinger, Administrator Diagnostic Health of Anchorage	X	X	X	Sub	X	Aaron Woolrich
2	Imaging	Jeff Kinion, CEO Alaska Open Imaging Center Wasilla	X	X	X	X	X	
3	Imaging	**Robert Bridges, MD Aurora Diagnostic Imaging, LLC, Fairbanks**	X	X	X	X in am only pm = Sub	X	Kim Black sub in afternoon
4	Imaging	Chakri Inampudi, MD Alaska Radiology Associates Anchorage	X	X	X*	X	X	*Left prior to meeting end on 11/13
5	Imaging	**Bradley K. Cruz, M.D. Alaska Imaging Associates, LLC, Anchorage**	X	X	X	X	Sub	Lester Lewis, MD

	Representing	Name	10/29	10/30	11/13	11/14	11/20	Substitutions
6	Hospital	Shawn Morrow, CEO Bartlett Regional Hospital Juneau	X	X	X	X	X	
7	Hospital	James Shill, CEO Northstar Behavioral Health Systems, Anchorage	X	X	X	A	X	
8	Hospital	Edward Lamb, CEO Alaska Regional Hospital Anchorage	Sub	Sub	A	A	Sub	Jordan Herget = 10/29 & 10/30 Paul Morris = 11/20
9	Hospital	E. Al Parrish, CEO/VP Providence Health System Anchorage	X in am only pm = Sub	X in am only pm = Sub	Sub	Sub	Sub	Joel Gilbertson 4/5 of sessions
10	Hospital	Mike Powers, CEO/Administrator Fairbanks Memorial Hosp./Denali Center Fairbanks	X	X	X	X	X	
11	Hospital	Norman Stephens, CEO Mat-Su Regional Medical Center, Palmer	X	X	Sub	Sub	X	Michael Zielaskiewkz
12	Hospital	Ryan K. Smith, CEO Central Peninsula Hospital Soldotna	X	X	Sub	Sub	X	Jason Paret
13	Physician group	Creed Mamikunian, M.D., Anchorage	X	X	X	X (am only)	Sub	Vicki Crumptoula
14	Physician group	Baxter Burton, CEO Alaska Heart Institute, LLC Anchorage	X	X	X	A	X	
15	Physician group	Gerald L. Nicholson, Administrator Katmai Oncology Group, LLC Anchorage	A	A	A	X	A	
16	Physician group	Jeremy Hayes Advanced Medical Centers of Alaska Anchorage	X	X	X	Sub in am / X pm	X	Cathy Giessel
17	Physician group	Bruce Jayne Alaska Surgery Center	X	X	X	X	Sub	William Pethick

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11	Hospital	Norman Stephens, CEO Mat-Su Regional Medical Center, Palmer	X	X	Sub	Sub	X	Michael Zielaskiewkz
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16	Physician group	Jeremy Hayes Advanced Medical Centers of Alaska Anchorage	X	X	X	Sub in am / X pm	X	Cathy Giessel
17	Physician group	Bruce Jayne Alaska Surgery Center	X	X	X	X	Sub	William Pethick

18	Association (physician)	J. Ross Tanner, ASMA President	Sub	Sub	A	A	Sub	ASMA E.D. James Jordan served as designated substitute
19	Tanana Chiefs	Victor Joseph, Health Director Tanana Chiefs Conference Health Svcs, Fairbanks	X	X	X	X*	X	*Left prior to meeting end
20	DHSS	Jay Butler, MD, FAAP, FACP Chief Medical Officer, DHSS Anchorage	X	X	X	X	X	
21	Association (hospital and nursing home)	Rod Betit, CEO Alaska State Hospital & Nursing Home Association	X	X	X	A	X	
22	Physician group	Mark Wade, MD. Fairbanks	NA	NA	X	X	A	Late entry to committee, Resigned after 11/14 meeting

II. Committee Negotiation Processes

A set of ground rules for discussion was implemented throughout the committee meetings;

ESTABLISHED GROUND RULES:

- Seek first to understand then to be understood
- Speak directly to your point
- Respect everyone's choices as right for them
- Spend 10% of your time identifying concerns & issues, 90% of your time identifying options & solutions
- Focus on choices and consequences versus right and wrong
- All Voices count
- Follow facilitator instructions

The committee used open group discussion to determine topics and points of view on each subject and questions for voting were developed. Voting was conducted using an electronic anonymous (Consensor) polling system to determine the level of consensus of the group on specific topics.

	Representing	Name	10/25	10/30	11/13	11/14	11/15	Comments
18	Association (physician)	J. Ross Tanner, ASMA President	Sub	Sub	A	A	Sub	ASMA E.D. James Jordan served as designated substitute
19	Tanana Chiefs	Victor Joseph, Health Director Tanana Chiefs Conference Health Svcs., Fairbanks	X	X	X	X*	X	*Left prior to meeting end
20	DHSS	Jay Butler, MD, FAAP, FACP Chief Medical Officer, DHSS Anchorage	X	X	X	X	X	
21	Association (hospital and nursing home)	Rod Betit, CEO Alaska State Hospital & Nursing Home Association	X	X	X	A	X	
22	Physician group	Mark Wade, MD Fairbanks	NA	NA	X	X	A	Late entry to committee, Resigned after 11/14 meeting

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Testimony on HB 337
Jeannine C. Hinman, JD

Director, Regulatory & Government Affairs
Advanced Medical Centers of Alaska

Madame Chairwoman, Members of the Committee, I am here today representing my company in support of the Governor's Bill and particularly in support of repealing the Certificate of Need Program here in Alaska.

There are 4 general reasons we support the Governor's Bill and we have provided data for each of these reasons. We believe the data demonstrates that:

1) Repealing the CON will increase the quality of medical care here,
2) Repealing the CON will improve access to care; and
3) Lead to more physicians coming to this state.
4) Repealing the CON will actually lower, not raise, the costs of care for the consumer and the state.

We hope the committee will carefully assess our data and the sources of it. There are a lot of claims being made by the out of state corporations who wish to retain the CON program as it is today. I urge you to question their claims, and assess the relevance and objectivity of their sources, and look at who benefits the most from CON because it is not the Alaskan consumer or patient.

Originally the CON program was designed to reduce redundancies and increase efficiencies of resources for health care as a way to keep costs down and help the patients. It has failed. The Governor's bill is NOT about attacking locally owned hospitals. On the contrary, the large hospitals here are owned by out of state corporations who are trying to prevent local doctors from opening any type of business that they feel encroaches on their market share.

The scare tactics the hospitals use include the idea that they'll all go bankrupt if anyone dares to provide health care other than them. Repealing the CON will not lead to The financial disaster they claim. In fact, both Providence and Fairbanks Memorial are owned or operated by out of state corporations who are flourishing and within those corporate health care systems the hospitals INSIDE Alaska, are reportedly their most profitable.

We urge you to read their financial statements and reports carefully scrutinizing their medical loss ratios, which translates to profit margin. For instance, in 2005, FMH reported in their CON application, of January of 2007, that their revenue/costs per day ratio is 1.38. This translates to a 38% profit margin. Not bad.

AHIP

AHIP Board of Directors Statement on Promoting a Value-Based Health Care System through Transparency

Approved by AHIP Board of Directors on November 9, 2006

Over the last decade, studies by the Institute of Medicine (IOM), RAND, Dartmouth and others have revealed alarming problems in the U.S. health care system, including wide variations in care across the country, high numbers of medical errors and medical practice which is often not based on scientific evidence. At the same time, our country spends approximately 16% of its gross domestic product on health care, and according to recent studies, an estimated 30% of health care expenditures are the result of poor quality care. Dartmouth research has confirmed that quality of care is worse in areas of higher utilization and spending. Moreover, reduced productivity due to absenteeism purportedly has cost our country an additional $105 - $210 billion per year.

In 2001, the IOM stressed in its report, *Crossing the Quality Chasm*, that transparency should be a key element of any strategy to improve clinical quality and achieve better value in the health care system. As consumers become increasingly involved in making decisions about the health care treatment they receive, more reliable and useful data on services provided by physicians and hospitals will enable them to make more informed decisions about where to seek care and assure that the care they receive meets their individual needs. Additionally, more information, which can help consumers choose physicians and hospitals which deliver value-based care, can result in significant savings across the health care system.

Various stakeholders representing a variety of constituencies are advancing transparency initiatives. Last August, President Bush signed Executive Order 13410 "Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs," which requires federal health programs to make quality and price information available to consumers. Additionally, more and more states make quality and cost information publicly available. At least 25 states make health care data available through dedicated websites, including a Florida state website where consumers can access quality, price and performance data on certain conditions and procedures at state hospitals and ambulatory (outpatient) surgery centers. At least 39 states and the District of Columbia have laws that require hospitals and in some cases, other providers to report financial information for health care services.

Health insurance plans have taken important steps – working with physician groups, hospitals, consumers, employers and government representatives through the AQA alliance and the Hospital Quality Alliance – to address gaps in quality and promote transparency of results and decisions by developing uniform processes to evaluate and report on care delivered to patients, and enable practitioners and hospitals to determine how their performance compares with their peers in similar specialties or other hospitals. AHIP also is an active member of the recently created Quality Alliance Steering Committee, convened by HHS Secretary Leavitt, which is assisting and providing recommendations to the Administration as it implements its broader health care transparency initiative.

Our community has made a commitment to working collaboratively with other stakeholders to promote a transparent, value-based health care system. As we participate in these various initiatives, we will advance the following principles:

Supporting a uniform approach for the disclosure of relevant, useful, actionable and understandable information to facilitate consumer decision-making and choice. Information should be made available to enrollees to permit accurate comparisons of physicians, hospitals and other practitioners. Additionally, information should be disclosed and displayed in a format that is easily accessible and understandable; consumers should be educated on how to use the information as appropriate.

Supporting efforts that advance transparency while preserving competition and basing analyses on objective, agreed-upon measures. Consumers and purchasers need accurate information to make more informed health care decisions. At the same time, the disclosure of this information should comport with antitrust guidelines to ensure that vigorous competition continues to thrive in the marketplace. To achieve this objective, ranges – such as the 25th percentile and 75th percentile of payments to hospitals which are disclosed by Medicare – should be the model for disclosing price information.

Recognizing the importance of linking quality and cost of care. Disclosure of information about the quality of care which physicians and hospitals provide and costs of services is important to enable consumers and purchasers to evaluate their health care options, and to enable practitioners to learn how their practices compare to their colleagues' practices in terms of effectiveness and efficiency. At the same time, consumers need assistance in interpreting this information and using these data to make informed decisions.

Developing the tools to analyze high-utilization, high-cost services or conditions where variation exists. The nation needs to build the capacity to analyze certain agreed-upon episodes of care as well as certain services or procedures. Presenting data on episodes of care (*e.g.*, pregnancy) – rather than merely on services (*e.g.*, labor and delivery) – will allow consumers to make more comprehensive and informed assessments. The episodes of care selected should align with conditions which address areas where practice variation exists, have high utilization rates and are known to be cost drivers.

Supporting the disclosure of information for physician as well as hospital services. To promote continuity of care and prevent the proliferation of silos within the health care system, stakeholders should advocate for the disclosure of physician performance information as well as the disclosure of hospital performance information. Disclosure of information for other providers – such as nursing homes and home health agencies – also should be considered.

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Health chief for state gets cold shoulder

GREGG ERICKSON
COMMENT
(02/24/08 00:45:03)

Karleen Jackson, who heads the Department of Health and Social Services, is the boss of 3,500 employees, supervises a budget of $2 billion, and is responsible for the health and well-being of every Alaskan.

Oh, and one other thing. Jackson and her $2 billion budget are in trouble.

Jackson is a pleasant, soft-spoken woman with a doctorate in human services who appears younger than her 55 years. Jackson's problem is that she has lost credibility with the Republican legislators with the most experience in dealing with her department's budget, the same legislators who in the past were the department's most important advocates in the House and Senate.

"I used to have tremendous trust in the department," Rep. Mike Hawker told me last week. For six years Hawker has chaired the House Finance subcommittee that reviews the department's budget: "When you have someone's trust, you can talk and speak about issues without it becoming a political hot potato. ... We're definitely feeling a trend towards having to fight in a more combative relationship with the department for information that used to just be much more forthcoming."

For years Lyda Green, now the Senate president, chaired the Senate's budget subcommittee. Her assessment isn't as blunt as Hawker's, but tends in the same direction. She says the leadership issue at DHSS is a symptom of a larger problem: "There is kind of a pervasive uncertainty about where authority or responsibility lies. That's kind of unsettling."

To analyze the sources of Jackson's troubles one must understand where they fit into the three P's -- policy, politics and personalities. All three are implicated in Jackson's tribulations.

Anyone who's attended House subcommittee hearings on departmental budgets knows that the chamber's Republicans, led by House Finance Co-Chair Mike Chenault, believe their battle to keep a lid on the operating budget will be won or lost during years when the state is flush with cash. It's easy to preach budgetary restraint when oil prices are low, but a much tougher sell when oil prices are nudging past $100 per barrel. "If you let these programs expand, it gets in the base budget, and you have the devil's own time getting it out," Chenault says.

"Now is the time to shore up the foundations, not add new wings to the building," adds Hawker, repeating one of his favorite budget mantras. From that policy perspective, he and fellow Republicans who control the House are skeptical of any request that goes beyond maintaining the status quo in services. Unfortunately for Jackson, what Hawker believes he found when he dug into the budget for Medicaid, the state-federal program providing medical services to the poor, was a budget padded with $30 million that Jackson now acknowledges she doesn't need.

Jackson says the Medicaid request seemed reasonable when it was formulated back in December, but things change. "I am learning more and more about our budget every day," she told me in an

interview, laughing. "I suspect I'm going to learn more things that are in there that I don't know about, as time goes on."

For Hawker, though, it is one more piece of evidence that the department has lost its focus: "I'm very concerned about a loss of business orientation to our budget process. Like this (Medicaid issue), it creates an aura of distrust."

There are personality issues as well, including legislative dismay over the departure in January of Janet Clarke, the department's former chief of finance and administration. Legislators say Clarke was forced out, an allegation Jackson denies, and on which Clarke has declined comment. Clarke is now assisting Hawker on budget issues.

And don't forget the politics. Gov. Sarah Palin is surfing on public approval ratings in the 85 percent range, but the same poll among Republican legislators would likely find 85 percent disapproval. Among the reasons is a perception, also common among lobbyists and many career state officials, that Palin doesn't care about the unglamorous side of government.

Few tasks in state government are less glamorous than the work of Health and Social Services, but it is an area legislators may be focusing on in the weeks ahead. Where that attention will take them is uncertain, but it is unlikely to be pleasant for the woman who runs the department or the governor who is her boss.

Economist Gregg Erickson is the owner of a Juneau consulting firm (www.EricksonEconomics.com).

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Here's one way to cut health care costs, improve quality

COMPASS: ***Other points of view***

By GOV. SARAH PALIN

(02/25/08 00:54:58)

Health care: Do we have too much government or too little? Should we have regulated markets or open markets?

Those are the perennial questions.

And that's what makes the state's proposal to repeal the current Certificate of Need (CON) program so contentious. Yes, there are solid arguments on both sides. But after much consideration, we believe that the program has not accomplished what it set out ultimately to do more than 30 years ago -- lower costs for the consumer. It is time to end Alaska's program in its present form. Doing so will not only reduce the cost of health care, it will also improve the access to health care, allow more competition and improve quality of care for patients

Certificate of Need programs were required in all states in the mid-1970s by federal mandate. The goal was to make sure that health care facilities matched community need and provided access and quality care, which in turn would help reduce health-care costs. The federal mandate was repealed in 1987 -- 20 years ago! -- along with its federal funding.

The basic assumption in those days was that excess capacity, in the form of overbuilding, directly results in health-care price inflation. However, after more than 30 years of such programs, the National Conference of State Legislatures has found that there is no solid proof that the state-sponsored CON programs have actually controlled health-care costs. In fact, in 2004 the Federal Trade Commission and the Department of Justice both asserted that these programs actually contribute to rising prices because they inhibit competitive markets.

Many opponents of CON programs have argued that health-care facility development should be left to the economics of each institution, in light of its own market analysis, rather than being subject to political influence.

My administration agrees.

I included repeal of Alaska's current program in my proposed Alaska Health Care Transparency Act (SB 245 and HB 337). The legislation will help Alaskans access affordable health care, and ensure our health-care system is responsive to changing demographics and market conditions. By getting information about health-care options to Alaskans, they can make better choices based on the health-care market.

The Certificate of Need is being used by lobbyists and health-care organizations to limit competition -- through appeal of other's certificate awards or by filing suit against the state for those awards. As one member of a citizen committee studying CON in 2007 put it: "the only voices heard (testifying for continuing CON even more stringently) were from the financially vested physicians and hospitals." Currently, there are seven active Certificate of Need lawsuits involving the state and private sector health-care providers

As I said recently in my State of the State Address to the Legislature, "Under our present Certificate of Need process, costs and needs don't drive health-care choices -- bureaucracy does. Our system is broken and expensive." Eliminating the CON program, with certain exceptions, will allow free-market competition and reduce onerous government regulation.

Sarah Palin is governor of Alaska.

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Michael G. McNamara, MD
Robert R. Thomas, MPAS, PA C, ATC

Feb 7, 2008

To: Representative Peggy Wilson and the HESS Ctte members

Re: House Bill 337 and House Bill 345, Committee meeting Feb 9th

For the record, I am Dr Mike McNamara an orthopaedic hand surgeon and the President of an advisory group that represents 26 limited surgeon partners to the Alaska Surgical Center in Anchorage Alaska.

I am in OPPOSTION to repealing the CON. My four comments deal only with this issue.

In discussing the CON, the purpose for the CON needs to be remembered. It was designed to prevent excessive, unnecessary and duplication of development.

First let me say, as many others that have already testified, I am very disappointed that the Governor and her staff have not paid more attention to the recommendations made by the Task Force for Negotiated Rule Making regarding the CON. It is my understanding over $50,000 was spent on mediation of a 5 day 21 member board that recommended overwhelmingly that the CON not be repealed.

Point two: In Anchorage the primary surgical centers include Alaska Regional, Providence, Alaska Surgical Center, and Alaska Spine. All of these centers are not to full capacity. The Alaska Surgical Center, was operating at only 55- 60% capacity this past year. We are fortunate in Anchorage to have Surgical Centers of Excellence. We have some of the best surgeons, nursing and support staff in the state. Many of the surgeons in Anchorage may even be the best in the country. Our community is thankful for this. Allowing additional surgical facilities to develop when our present centers are not to capacity would likely reduce vital PEER OVERSIGHT which exists in these centers of excellence, and may allow loss of appropriate STANDARDS OF CARE.

Point three: There is a national shortage of OR nursing, and all of these centers are under-staffed with respect to specialized OR nursing and OR support staff. Removing the CON in Alaska would create undo competition for OR staff and specialized skilled nursing where there is already a critical shortage. Competition will not lower costs, but will create greater costs in overhead while competing for these limited resources.

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Lastly, the larger centers, as they exist, have the power to negotiate contracts with insurance companies and unions, thus allowing reduced costs to the public. Un-checked development would likely reduce the negotiating power of existing centers and additional centers would drive the price of care upward. Un-checked competition in medicine, especially in Alaska, does not equate to reduced prices like the non-medical business models!

Madame Chair and members of the committee, I would urge you to NOT REPEAL the CON. Do not risk loosing the awesome "Center of Excellence" approach to health care that we presently have working well for us in Alaska, at the risk of compromising standards of care. Remember, it was only several years ago that specialty care was sent out to Mayo Clinic, Seattle or other centers of excellence. We now have our own "centers of excellence" with exceptional surgeons in our own great state of Alaska.

Thank you for your attention and consideration with this vital issue. I plan to testify before the House on Feb 9th regarding the CON.

Sincerely,

Michael G. McNamara MD
Hand, Elbow, and Shoulder Surgery
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Anchorage, Alaska 99505

Contact Info: W 907 771-3500
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mmcnamara@akhanddoc.com

Subject: Eliminate the Certificate of Need 2/5/08 HB 337, SB 245

From: Carter Crawford 167 Maple Dr. Fairbanks Ak. 99709
347-9223 cell

I have just read Mike Power's editorial describing in excellent detail the challenges facing the Fairbanks medical community to provide quality medical personnel. He goes to great lengths to detail how Fairbanks Memorial Hospital has made this a community effort, presumably for the benefit of all clinics.

He fails to point out, however, that the biggest clinic is about to merge into the Hospital, that all clinics use FMH, so 99% of the benefits of team recruiting go to FMH. And of course he makes no mention of the $9 million profit sent to parent Banner Health last fiscal period, or that all recent additions like the Imaging Center and Cardiac Wing are extremely profitable under any circumstances

I have a 25-year history of support for Fairbanks Memorial Hospital, as an in and outpatient and Auxiliary Volunteer. However I find the CON outdated, outrageous and bad policy.

The original purpose of cost containment has long since been eliminated, and Fairbanks Memorial Hospital/Banner Health has arbitrarily replaced it with political protection for their monopoly. It now protects FMH so well that they sent $9 million in profits to parent Banner Health last year while denying any other facility to build.

CON was not intended to insure a profitable non-profit monopoly.

CON was not intended to kill private enterprise

CON was not supposed to reduce quality of medical service and create lengthy delays and increase patient costs.

But CON does all of these in Fairbanks, and from personal experience the past two years.

I have heard potential physician recruits turn down jobs in Fairbanks because of the lack of surgical facility choices. He has intentionally well covered the other reasons, but purposely omitted this one.

My internist quit private practice to work at the hospital leaving numerous patients without a physician. Had there been another clinic with surgical suites, she might have selected it and many patients could have followed her. There were several reasons, but the time spent on administrative work was clearly high on the list.

4-8 week delays for outpatient surgery. It was scheduled about 4 weeks out and had to be rescheduled due to a day of emergency and rescheduled another 4 weeks out.

Surgical error while performing carpel surgery, which has caused permanent damage to my hand. The hall looked like the DMV, but with patients on gurneys, all waiting for surgery.

And my stories are minor compared to the lost x-rays, x-rays of the wrong wrist, 4 day waits to set bones, delivery of wrong meds, too early release, refusing mammograms to those without insurance, ignoring or refusing doctors orders (one time the doctor happened by and I wish I had been there).

One significant argument for CON used by FMH is they would be left with all the no insurance patients. That is preposterous. Both the outpatient proposals to the state recently have agreed to take a portion of no pay clients. And if there is an alternative service the hospital can send no pay patients to they most certainly do. For a mammogram FMH will send you to Breast Cancer Detection Center the second they hear "I have no insurance." And I might ad, BCDC had hired a mammography technologist from outside, offered her a 50% moving allowance and a nice bonus which she accepted: but FMH recruited her, offered full moving and a better bonus.

FMH would lead you to believe they have all the no pay patients and nothing is further from the truth. The clinics take them, BCDC takes them, and I am sure the Nurse Practioner is not alone in taking them.

But we have no alternative.

It is incredible that the state and our legislators, based on state legislation even the federal government has eliminated, allow a monopoly to continue and deny one of America's most basic principals, FREE ENTERPRISE, to dictate market conditions.

THE STATE DOES NOT OPERATE ON SOLE SOURCE BIDS for the most part, why must Fairbanksans in need of medical service?

In closing, none of the arguments presented by Fairbanks Memorial Hospital to keep CON are valid.

We have a growing population, now close to 100,000

The demand far exceed availability, with 4-8 week waits for outpatient surgery

The costs are much higher than Anchorage. One local Union testified at the public hearing here last year that they were flying patients to Anchorage for treatment because it was cheaper, including the fare, to do so

PREPARED STATEMENT OF
THE FEDERAL TRADE COMMISSION

Before the

STANDING COMMITTEE on HEALTH, EDUCATION & SOCIAL SERVICES

of the

ALASKA HOUSE OF REPRESENTATIVES

on

House Bill 337, "An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; relating to the certificate of need program for certain health care facilities; and providing for an effective date."

February 15, 2008

I. Introduction

The Federal Trade Commission (FTC) is pleased to have the opportunity to discuss health care competition, Alaska's certificate of need (CON) laws, and Alaska House Bill 337 (H.B. 337), which would modify certain of Alaska's CON laws.[1] The Commission believes that CON laws such as Alaska's can be a barrier to entry to the detriment of health care competition and health care consumers, and that the legislature should consider their repeal. The Commission's conclusion is based on the joint FTC/Department of Justice (DOJ) report, *Improving Health Care: A Dose of Competition* (Report or FTC/DOJ Report),[2] its underlying research, and recent work by FTC staff and the staffs of our sister agencies, such as DOJ and the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services. As noted in the FTC/DOJ Report, "[t]he Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[3]

Congress has charged the Commission with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[4] Pursuant to its statutory mandate, the FTC seeks to identify business practices and regulations that

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[1] The FTC initially was invited to submit testimony regarding H.B. 337, as introduced on January 22, 2008, which would have repealed Alaska's CON requirements generally; a more recent committee substitute draft also before the relevant Alaska house committee (but not yet available publicly) would repeal only certain of Alaska's CON requirements, but leave others – such as those regarding nursing homes – intact.

[2] FEDERAL TRADE COMMISSION & THE DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July, 2004) [hereinafter "IMPROVING HEALTH CARE"].

[3] *Id.* at Executive Summary, p. 22.

[4] Federal Trade Commission Act, 15 U.S.C. ' 45.

impede competition without offering countervailing benefits to consumers. For several decades, the FTC and its staff have investigated the competitive effects of restrictions on the business practices of health care providers.[5] Included in that general body of health care competition work have been hearings, studies, and reports addressing issues raised by CON laws.

Specifically, the FTC/DOJ Report discusses critically the role of CON laws in health care competition, both as a distinct policy issue and as an important component of other health care competition issues, such as entry problems in hospital markets. The Report broadly examined the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying the preferences of Americans for high-quality, cost-effective health care. The Report was based on, among other things, joint FTC/DOJ hearings that took place over 27 days from February through October 2003, following a Commission-sponsored workshop on health care issues in September 2002. The FTC and DOJ heard testimony from about 240 panelists, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from antitrust and economics to health care quality and informed consent. Together, the hearings and workshop elicited written submissions from interested parties. Almost 6,000 pages of transcripts of the hearings and workshop and all written submissions are available on the Commission website, www.ftc.gov. In addition, FTC and DOJ staffs undertook independent research for the Report.

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[5] *See* Federal Trade Commission, *FTC Antitrust Actions in Health Care Services and Products* (Oct. 2003), *available at* http://www.ftc.gov/bc/hcupdate031024.pdf.

In this testimony, the Commission focuses specifically on a few of the issues discussed in the Report that address CON laws and new entry into competition among health care facilities. Three main points require attention:

- First, vigorous competition among healthcare providers, such as hospitals, clinics, and nursing homes, usually benefits consumers through better and more varied services and, in some cases, lower prices. CON laws were designed to create barriers to entry for new healthcare facilities or providers to contain the costs of healthcare services. CON laws, however, have not been particularly effective in controlling healthcare costs, while posing significant risks to competition. In particular, CON laws can retard the entry of firms that could provide higher quality services or lower prices than those offered by incumbents, depress consumer choice between qualitatively different treatment options or settings, or reduce the pressure on incumbents to improve qualitative aspects of their own offerings. Policymakers would be wise to consider reviewing all of the actual costs, benefits, and consequences – intended and unintended – of a regulatory system when assessing that system's future.
- Second, the CON regulatory system creates both the incentive and means by which an incumbent healthcare provider can use the regulatory system itself to delay effective competition, independent of the demand for additional healthcare services. This additional loss of competition is another regulatory cost that must be weighed in the balance when assessing the public interest.

- Finally, Alaska currently has one of the most stringent CON laws in the United States. House Bill 337's proposed amendment of this law would eliminate or reduce barriers to entry for a broad range of healthcare service providers, including small entities that might then be able to thrive as never before.

These points are addressed more fully, below.

II. Discussion

A. Provider Competition Generally: Competition has important benefits in health care services markets, just as it has in the multitude of markets in the U.S. economy that rely on competition to maximize the welfare of consumers. Competitive pressures can lead hospitals and other entities to lower costs, improve quality, and compete more efficiently. In particular, competitive pressure may spur new types of competition. In some hospital markets, new entrants specialize and provide only a limited portion of the in-patient and out-patient services that general hospitals tend to provide.[6] Elsewhere, health care services once delivered only in large hospitals – and requiring overnight stays – may be performed more conveniently and less invasively, at lower cost, in outpatient settings. In addition, both traditional providers and new entities have explored new means to expand access to basic health care by, for example,

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[6] *See generally Prepared Statement of the Federal Trade Commission, Before the S. Subcomm. On Federal Financial Management, Gov't Information and Int. Security of the S. Comm. on Homeland Security and Governmental Affairs, on New Entry Into Hospital Competition* (May 24, 2005) (regarding, e.g., new specialty hospital entry), *available at* http://www.ftc.gov/os/2005/05/052405newentryintohospitalcomp.pdf; *see also* UNITED STATES DEPT. OF HEALTH AND HUMAN SERVICES, FINAL REPORT TO THE CONGRESS AND STRATEGIC IMPLEMENTING PLAN REQUIRED UNDER SECTION 5006 OF THE DEFICIT REDUCTION ACT OF 2005 (2006) [hereinafter "HHS FINAL REPORT"], *available at http://www.cms.hhs.gov/PhysicianSelfReferral/06a_DRA_Reports.asp.*

establishing limited service clinics that can provide more convenient and lower cost care and bring more consumers into contact with the larger health care system.[7]

Although new strategies for lowering costs and enhancing quality are emerging, competition is not as effective as possible in most health care markets, because the prerequisites for competitive markets are not fully satisfied. Of particular concern for today's purpose is the extent to which state regulations can create barriers to entry in health care markets, without conferring countervailing benefits in quality of care or cost containment.[8]

At the same time, the empirical evidence generally does not indicate that CON laws control health care costs.[9] Recent broad studies analyzing both national and state

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[7] *See, e.g.*, FTC Staff Comment Before the Massachusetts Department of Public Health Concerning Proposed Regulation of Limited Service Clinics, 1-2 (Oct. 2007).

[8] In discussing competition concerns raised by CON requirements, the Commission does not mean to suggest that state CON regulations are the only regulatory impediments to competitive forces in health care markets. For example, in testimony before the House Committee on Energy and Commerce on May 12, 2005, Mark McClellan, then Administrator of CMS, reported that CMS, following its own study of specialty hospitals pursuant to congressional direction, would analyze and reform its payment rates "to help reduce the possibility that specialty hospitals may take advantage of imprecise payment rates in the inpatient hospital prospective payment system" and "to diminish the divergences in payment levels [for ambulatory surgical centers] that create artificial incentives for the creation of small orthopedic or surgical hospitals." *Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, Before the H. Comm. on Energy and Commerce Hearing, "Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care,"* (May 12, 2005), *available at* http://www.hhs.gov/asl/testify/t050512.html; *see also Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, on Physician-Owned Specialty Hospitals Before the S. Finance Comm.* (May 17, 2006), *available at http://www.hhs.gov/asl/testify/t060517b.html*.

[9] IMPROVING HEALTH CARE, *supra* note 2, at C. 8, at pp. 1-6. Although the larger body of CON literature – including anecdotal reports and small, uncontrolled studies – presents somewhat mixed conclusions on cost savings, the conclusions of the FTC/DOJ Report and staff research have substantially been borne out by more recent, sophisticated large-scale data analyses and literature reviews: "[O]n balance, the most methodologically sound studies have found that CON has no effect or actually increases both hospital spending per capita and total spending per capita." CHRISTOPHER J. CONOVER & FRANK A. SLOAN, EVALUATION OF CERTIFICATE OF NEED IN MICHIGAN, CENTER FOR HEALTH POLICY, LAW AND MANAGEMENT, TERRY SANFORD INSTITUTE OF PUBLIC POLICY, DUKE UNIVERSITY, A REPORT TO THE MICHIGAN DEPT. OF COMMUNITY HEALTH, 30 (May 2003) (reviewing literature and discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws) (hereinafter "CONOVER & SLOAN, REPORT TO MICHIGAN"), WASHINGTON STATE JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE (JLARC), EFFECTS OF CERTIFICATE OF NEED AND ITS POSSIBLE REPEAL, 1 (Jan. 8, 1999) ("The study found that CON has not controlled overall health care spending or hospital costs.

data reveal "little evidence that CON results in a reduction in costs and some evidence to suggest the opposite."[10] Studies also fail to show any consistent increase or surge in health care spending when states remove or modify their CON requirements.[11]

Barriers to entry can affect qualitative competition as well. As the Report noted, state CON laws can retard the entry of firms that could provide higher quality services than those offered by incumbents.[12] That may tend to depress consumer choice between qualitatively different treatment options or settings,[13] or it may reduce the pressure on incumbents to improve qualitative aspects of their own offerings.

The study generally found either conflicting or limited evidence about the effects of CON on the cost of non-hospital services, and on the quality and availability of the various health care services.") DANIEL SHERMAN, FEDERAL TRADE COMMISSION, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS, iv, 58-60 (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data on 3,708 hospitals, that strong CON programs do not lead to lower costs but may actually increase costs); MONICA NOETHER, FEDERAL TRADE COMMISSION, COMPETITION AMONG HOSPITALS 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); KEITH B. ANDERSON & DAVID I. KASS, FEDERAL TRADE COMMISSION, CERTIFICATE OF NEED REGULATION OF ENTRY INTO HOME HEALTH CARE: A MULTI-PRODUCT COST FUNCTION ANALYSIS (1986) (economic study finding that CON regulation led to higher costs, and that CON regulation did little to further economies of scale). *But c.f.*, COMMONWEALTH OF VIRGINIA, REPORT OF THE JOINT COMMISSION ON HEALTH CARE, HOUSE DOC. NO. 82, STUDY OF VIRGINIA'S CERTIFICATE OF PUBLIC NEED (COPN) PROGRAM PURSUANT TO HB 1302 OF 1996 (1997), ("There is little evidence of significant COPN impact on aggregate health expenditures, but there is evidence of savings for specific services covered by COPN"). *Id.* at 1, *available at* http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD821997/$file/HD82_1997.pdf?besi_scan_129F6A3CDB83467E=xLesgwML73sPV18TFUnlHEOAAAD+O30W&besi_scan_filename=HD82_1997.pdf (last checked 1/31/08).

[10] CONOVER & SLOAN, REPORT TO MICHIGAN, *supra* note 9 at vii (discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws); *id.* at 30-31.

[11] CONOVER AND SLOAN also report that, "[i]n most states that lifted CON, per capita spending on hospital and physician services (relative to the US) has remained below the U.S. average following removal of CON.") *Id.* at 50; *see also* Christopher J. Conover and Frank A. Sloan, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL'Y & LAW 455 (1998) ("no evidence of a surge in acquisition of facilities or in costs following removal of a CON.") 458.

[12] IMPROVING HEALTH CARE, *supra* note 2, at C. 8, p. 4 (citing Hosp. Corp. of Am., 106 F.T.C. 361, 495 (1985) (Opinion of the Commission) (stating that "CON laws pose a very substantial obstacle to both new entry and expansion of bed capacity in the Chattanooga market" and that "the very purpose of the CON laws is to restrict entry").

[13] With regard to hospital markets, *see, e.g.*, HHS FINAL REPORT, *supra* note 6, at 10 (reporting "quality of care at least as good as, and in some cases better than, care provided at local competitor hospitals" for

B. Incumbent Lobbying and Petitioning Protections: When new firms threaten to enter a market, incumbent firms may seek to deter or prevent that new competition. Such conduct is by no means unique to health care markets; it is a typical reaction of incumbents to possible new competitors. In certain circumstances, such conduct may violate the antitrust laws.[14] Certain anticompetitive conduct may, however, be shielded from antitrust scrutiny. The *Noerr-Pennington* doctrine immunizes from antitrust liability conduct that represents petitioning the government, even when such petitioning is done "to restrain competition or gain advantage over competitors."[15] Moreover, the state action doctrine shields from antitrust scrutiny many of a state's own activities when a state government is acting in its sovereign, legislative capacity.[16]

In the context of health care competition, the combination of these two doctrines can offer antitrust immunity to providers that wish to lobby state officials to impede the entry of potential competitors, by denying or delaying the CONs required for operation. State CON programs generally prevent firms from entering certain areas of the health

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cardiac care, as well as "very high" patient satisfaction in cardiac hospitals and orthopedic specialty hospitals) (citations omitted). In addition, specialty hospitals appear to offer shorter lengths of stay, per procedure, than peer hospitals. *See* MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS, 15-17 (Mar. 2005) (hereinafter MEDPAC REPORT). MedPAC was directed to report to Congress on certain issues regarding specialty hospitals under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. *Id.* at vii.

[14] *See* IMPROVING HEALTH CARE, *supra* note 2, at 15-16, ch.1, at 31-33, ch 3, at 22-27.

[15] Andrx Pharm. V. Biovail, 256 F.3d 799, 817 (D.C. Cir. 2001), *cert. denied*, 122 S. Ct. 1305 (2002). The doctrine is named for the seminal cases that treated it: Eastern R.R. Presidents Conference v. Noerr, 365 U.S. 127 (1961), and United Mine Workers v. Pennington, 381 U.S. 657 (1965).

[16] Parker v. Brown, 317 U.S. 341, 351 (1943). The state action doctrine also immunizes from antitrust scrutiny the actions of other entities and individuals if they are acting in furtherance of a clearly articulated state policy and are actively supervised by the state. *See, e.g.*, California Retail Liquor Dealers Assn. v. Midcal Aluminum, 445 U.S. 97, 105 (1980).

care market unless they can demonstrate to state authorities an unmet need for their services. Because that demonstration can be time-consuming and costly, it may delay or, at the margin, prevent the introduction of certain needed facilities and services.[17] Indeed, limiting competitor entry and raising competitors' costs may both be incentives for incumbents to seek to abuse the regulatory process. The FTC/DOJ Report concluded that "incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market."[18] To the extent they are successful in doing so, incumbents may preserve their market shares and revenue streams without enhancing their own operating efficiency or providing health care savings to the state or its consumers.[19]

C. **The Scope of Alaska CON Law:** Alaska's current CON law is among the most stringent of such laws in the United States. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974,[20] which offered states powerful incentives to enact laws implementing CON programs.[21] By 1980, all states except Louisiana had done so.[22]

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[17] *See, e.g.*, IMPROVING HEALTH CARE, *supra* note 2, at C. 4, p. 25 (noting that approval of a CON "can take anywhere from 18 months to several years," and that regulatory delays from CON approval are in addition to those imposed by, for example, traditional licensing requirements).

[18] *Id. at* Exec. Summ., at 22.

[19] *See, e.g.*, MEDPAC REPORT at 10-11 ("Some community hospital administrators admit that competition with specialty hospitals has had some positive effects on community hospitals' operations").

[20] Pub. L. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k-300n-5), *repealed*, Pub. L. 99-660, § 701, 100 Stat. 3799 (1986).

[21] *See* JOHN MILES, 2 HEALTH CARE & ANTITRUST LAWS: PRINCIPLES & PRACTICE § 16:1, at 16-2 (2003) (noting that the federal Health Planning Act required providers to "obtain state approval – a 'certificate of need' – before spending set amounts on capital investments or adding new health care services.")

[22] *See, e.g., On Certificate of Need Regulation: Hearing on H.B. 332 Before the Senate Comm. On Health and Human Services* (Ohio 1989) (Statement of Mark D. Kindt, FTC Regional Director).

Congress repealed the federal law in 1986, however, and many states have repealed or revised their CON laws in the years since. Fourteen states have eliminated their CON requirements altogether[23] and although a substantial number of states continue to maintain CON programs,[24] they do so "often in a loosened form compared to their predecessors."[25] Remaining CON laws may address only specific types of health care facilities – such as hospitals or nursing homes,[26] – exempt certain types of health care facilities,[27] or apply broadly to health care facilities improvements of a greater magnitude.[28] In addition, certain CON laws may be pending repeal according to a sunset provision.[29]

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[23] *See, e.g.*, National Conference of State Legislatures, *Certificate of Need: State Health Laws and Programs* (updated Nov. 2007) (CON laws repealed or not in effect in CA, AZ, NM, TX, KS, CO, UT, WY, ID, SD, ND, MN, IN, and PA), *available at* http://www.ncsl.org/programs/health/cert-need.htm (last checked 01/25/08).

[24] MILES, *supra* note 21, § 16:2, at 16-9 (stating that "CON laws remain in many states and the District of Columbia"). Quite recently, Florida exempted from CON requirements new adult open-heart surgery and angioplasty programs at general hospitals and the addition of beds to existing hospital structures. Fla. Bill SJ 01740 (effective July 1, 2004), *amending* FLA STAT. ch. 408.036, .0361 (2003).

[25] MILES, *supra* note 21, § 16:1, at 16-2 to 16-3. *See also* Len M. Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning*, 23 HEALTH AFFAIRS 1, 11 (Mar./Apr. 2004) (noting that CON programs "eroded through the 1990s").

[26] *See, e.g.*, OAC Ann. 3701-12-05 (2007) (regarding only certain activities by "long-term care" facilities in Ohio), R.R.S. Neb. § 71.5829.03 (2007) (CON covers only certain activities related to long-term care and rehab beds in Nebraska); ORS § 442.315(1) (2005) (regarding "any new hospital or new skilled nursing or intermediate care service or facility" in Oregon, subject to certain exclusions).

[27] For example, Connecticut law exempts critical access hospital beds and related equipment from the State's CON laws. *See* Conn. Gen. Stat. § 19a-487a (2007); *see also* Fla. Stat. § 408.0361 (2007) (regarding cardiovascular services and burn unit licensing), Fla. Stat. § 408.036 (2007).

[28] For example, Connecticut health care facilities must obtain a CON prior to developing, expanding or closing certain services and expending more than $3 million on a capital project. Conn. Gen. Stat. § 19a-638(a)(4) (2007); Delaware requires a CON for the establishment of a new facility, but only for capital expenditures by existing facilities in excess of $5.8 million (or a higher amount based on inflation adjustments to the $5.8 million baseline). *See* 16 Del. C. § 9304 (2007).

[29] *See, e.g.* 16 Del. C. § 9311 (2007) (sunset provision).

Alaska law requires a CON for any type of health care facility construction or improvement of $1,000,000 or more, adjusted,[30] or the establishment of a nursing home facility independent of that cost threshold.[31] In so doing, it places significant regulatory burdens on the development or improvement of a very broad class of health care facilities – not just major hospital initiatives and expansions, which may be subject to long-term planning – but diverse outpatient clinic initiatives, which might otherwise develop dynamically in response to market needs. The scope of current Alaska law thus stands in contrast not only to the laws of those states that have eliminated their CON requirements altogether, but the laws of the many states that have more limited CON requirements. Alaska's low CON threshold itself may be a special burden to the State's health care spending, as low CON thresholds have been observed to increase costs – relative to higher thresholds – rather than decrease them.[32]

A degree of controversy may remain about particular issues addressed by certain CON laws. These include, for example, efficiency and possible conflicts of interest concerns about certain categories of physician-owned specialty hospitals and access issues for rural or other underserved areas.[33] However, the sweep of Alaska's CON law

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[30] Alaska Stat. § 18.07.031(a) (2007). The statute contains an adjustment provision, whereby the $ 1 million dollar threshold may be increased by $50,000 per anum, between 2005 and 2014. *Id.* at § 18.07.031(d).

[31] *Id.* at § 18.07.031(b).

[32] *See* SHERMAN, *supra* note 9, at 58-60 (1.4 percent decline in costs associated with doubling of all thresholds).

[33] *See, e.g.*, Testimony of Mark B. McClellan, M.D., Ph.D. (2005), *supra* note 8; Testimony of Mark B. McClellan, M.D., Ph.D. (2006), *supra* note 8 (regarding CMS studies of physician-owned specialty hospitals, implementation and termination of limited moratorium on new specialty hospitals). The Commission does not here intend to analyze the details of ongoing regulatory reform at CMS designed to address special concerns about certain limited types of specialty hospitals (and related physician self-referral issues) or the various bodies of research on which those reforms are based. The FTC notes, simply,

is much broader than required to address any of those more narrow and complex issues and is likely to be detrimental to Alaska's health care consumers. The Commission recommends that Alaska carefully consider the evidentiary basis of these issues as they may relate to Alaska health care consumers. If the evidence and public policy considerations warrant some legislative action, the Commission recommends that Alaska consider regulation that is narrowly tailored to achieve focused health policy goals instead of broad regulation of entry into the market for health care facilities.

III. Conclusion

CON laws were adopted throughout most states under particular market and regulatory conditions substantially different from those that predominate today and were intended to help contain health care spending. The best available research does not support the conclusion that CON laws actually reduce such expenditures. As the FTC and DOJ have said, "on balance, CON programs are not successful in containing health care costs, and ... they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[34] CON laws tend to create barriers to entry for health care service providers who may contribute to qualitative competition and provide consumers with important choices in the market, but CON laws do not, on balance, tend to suppress health care costs or aggregate health care spending. Moreover, CON laws may be especially subject to abuse by incumbent providers, who can seek to exploit a state's CON process to forestall the entry of competitors in their markets.

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that most of the actual and potential health care entities subject to Alaska CON law are not such specialty hospitals and appear to fall outside the concerns driving those studies and reforms.

[34] IMPROVING HEALTH CARE, *supra* note 2, at Executive Summary, p. 22.

Alaska's current CON law – which House Bill 337 seeks to modify – is among the most stringent of such laws in the United States. As a consequence, Alaska CON law creates a barrier to entry for a very broad range of health care service providers, including small health care entities that may be ill-equipped to overcome it. The Commission believes that both the breadth of Alaska's CON law, and its low threshold, are of special concern, as they may work to the detriment of Alaska health care consumers. In the event that adequate evidence develops to support more narrow policy priorities, the Commission believes that Alaska should consider regulations narrowly tailored to meet those priorities, while minimizing the general costs to Alaska health care consumers.

ALASKA ORAL & FACIAL SURGERY CENTER
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Representative Peggy Wilson
House HESS Chair
State Capitol, Room 108
Juneau, AK 99801-1182

February 23, 2008

Re: Support House Bill 337 – Certificate of Need

Dear Madame Chair,

While listening to the hearing on HB 337 on February 23, 2008, you brought up a very interesting point with regard to physician shortage in Fairbanks. You stated there are other factors which may cause physician shortage other than the CON law; such as the cold weather, long dark hours and spouses unable to shop in larger shopping centers. I would like to add even one more deterrent for locating in Alaska, specifically, Fairbanks which may be a great distance from other family members.

You stated there was no proof the CON law was the cause of the physician shortage in Fairbanks. This may be a true statement. However, out of all these variables only the CON law is the variable that can be changed. So by changing this restrictive law, at least, we may have a chance to recruit physicians since there is really no substantial reason not to eliminate this law.

It is well documented; the CON law is ineffective in serving its original purpose. The change in government regulations eliminates the original justification for the CON law. There is equally important documented evidence the CON law stifles entrepreneurship, innovations, competition, free markets, eliminates consumer choices, protects incumbent hospitals by keeping prices and profits high, as well as, protecting their health care monopoly. The CON law also limits the ability to recruit physicians.

It is also well documented there is no empirical evidence the CON program has been effective in reducing hospital or health-care costs. Contrary to pro-con advocates there is no documented evidence that the elimination of the CON has caused hospital closures, nor any evidence of harm to incumbent hospitals.

Furthermore, the Medicare Payment Advisory Commission has determined that specialty hospitals do not undercut the financial stability of community hospitals. Neither will ambulatory surgery centers. This Advisory Commission stated the current CON law gives hospitals a monopoly. They also stated there is no evidence showing a community hospital being forced to close as a result of competition from an ambulatory surgery center.

Alaska citizens have the right to the lowest-cost, highest quality care they can receive along with ability to chose their provider and obtain second opinions. With the present CON law citizens have lost many of these rights. The CON law is an outdated and abusive restrictive law which serves no purpose except to provide restriction in a corrupt health care monopoly.

Since the CON law is the only variable that we have the capability of changing, I believe it would be appropriate to eliminate the CON law and, at least, give Alaska, and specifically Fairbanks a fighting chance to recruit quality physicians.

I would like to reference an article in the Fairbanks Daily New-Miner, dated January 13, 2008. "Shortage of Physicians is a Real Health Care Crisis"; by Mr. Van Allen, President of Timeline Recruiting, a physician recruiting firm based in Columbia, MO.

What the article stated was some of the major reasons for the shortage in physicians in the U.S. is that many physicians are leaving their practice due to an increasing difficult work environment, rising cost of liability insurance, the constant threat of being sued and increasing administrative burdens. Even though we do not have the capability to change all these variables we do have the opportunity to change the adversarial work environment in Alaska with the elimination of the CON law.

With the upcoming physician shortage this author has predicted. Does anyone realistically believe we can recruit and retain physicians in Alaska with all the adverse variables you mentioned along with the anti-competitive, health care monopoly which we presently have under the protection of the CON law? Under the present conditions we can't even retain the physicians we already have.

I am asking for your support in the elimination of the certificate of need law (CON) in the state of Alaska. Please support HB 337.

Sincerely,

Stephen H. Sutley DDS, MA

cc: Governor Palin
Hess Committee HB 337

ALASKA ORAL & FACIAL SURGERY CENTER
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Representative Bob Lynn
State Capitol, Room 104
Juneau, AK 99801-1182

February 20, 2008

Dear Rep Lynn:

I am asking for your support in the elimination of the certificate of need law (CON) in the state of Alaska. Please support HB 337. America and Alaska need to be on the forefront of medical health care with the ability to recruit quality physicians and not be stifled by an outdated CON law, government bureaucrats or multibillion dollar hospital institutions dictating our health care.

Health care in America is not perfect but is the envy of the entire world. Health care is a major issue in the 2008 national elections. It should also be a major issue in the state elections as well. The public needs to be aware where their elected officials stand on this important issue.

Health care has evolved and changed over the years through unimpeded entrepreneurship and innovative ideas. Without change there can be no improvement and growth. Unfortunately, everyone resists change to some degree. The reasons are many; they include fear of the unknown, tradition or personal loss. However, change will happen whether we like it or not. Government controlled national health care is neither the answer nor are bureaucrats in multibillion dollar hospital institutions.

As one considers making a change in anything, one should consider what it is going to cost and whether the change is needed for improvement and growth. It is important to measure the cost of change compared to the cost of the status quo.

I believe our overall common goals include:

- **Improve the quality of health care, and ensure patient access to medical care, quality and quantity physicians to provide options and second opinions, and to;**
- **Contain or reduce the costs of medical care for patients and the state of Alaska, and;**
- **Ensure protection of patients rights that include:**
  - **The right to know their treatment options, including alternative treatment and the ability to obtain a second opinion.**
  - **The right to know the quality and cost of their doctor, hospital bills, drugs, devices and procedures before they make a decision.**
  - **The right to the lowest-cost, highest quality care they can receive.**

The cost of the status quo health care system to the public and Alaska is overwhelming. The present CON law provides protection for big business and multibillion dollar hospitals. It stifles entrepreneurship and innovative ideas and keeps price and profits high. Under the CON law patients have lost many of their rights to options, second opinions, and low cost quality health care. As long as Alaska maintains status quo under the present CON law, health care in Alaska will never progress and our residents will be the losers.

As I listened to the hearings on SB 245 and HB 337, by far, the majority of what I heard was testimony from short sighted special interest individuals and hospital employees protecting their turf. I found the hearings a bit disingenuous in that I did not hear much about serving the public or the betterment of society or the improvement of health care. Little time was provided to national professionals that have studied the effects of CON nationally and have published numerous articles on the adverse effects of the CON law. In fact, during the HB 337 hearing individuals were rudely cut short by the chairperson, myself included.

As you are aware the push for National Health Care is going to be a major issue in the 2008 elections. In my opinion, the CON law is just one facet of the problems with health care today and very importantly demonstrates what happens when government, politicians, (national and state) bureaucrats and lawyers get involved in the private sector. The real evidence is overwhelmingly clear for the necessity to eliminate the CON law in Alaska. CON law is:

- Anti-competitive, eliminates consumer choice and creates a hospital-based monopoly. It prevents access to healthcare that would otherwise be available.

- It is a source of corruption, by guaranteeing very high fees and profits to those who benefit from the CON law.

- It prevents physician recruitment, entrepreneurship and health care innovation in Alaska.

I would like to briefly address each of these issues.

There is a segment of our patient population that would benefit by being treated in an out patient ambulatory surgery center since their medical condition and treatment does not warrant hospitalization but extensive enough to be risky in a clinic setting. Safety is always a concern with patient care.

We don't have this capability in Fairbanks due to the CON law. When attempts were made to develop an ambulatory surgery center in Fairbanks, it was aggressively and successfully block by Fairbanks Memorial Hospital, resulting in costly delays with one appeal after another and, of course, multiple lawsuits. This pattern is also evident in other areas of the state with different hospitals.

Fairbanks Memorial Hospital with the aid of the CON law has successfully restricted and eliminated progress of health care in Fairbanks. This restriction has also limited physicians in providing patients with options and treatment.

The patients I referred to are either forced to be treated in the hospital, or have elected to seek treatment out of state, which is expensive and inconvenient for the patient and family support. Many patients can not afford either of these options and end up not receiving treatment, delaying treatment or end up being treated in our clinic or the ER on an urgent or emergency basis.

The CON law is not only focused on keeping out new forms of health care delivery, it even limits existing providers to serve their own communities. Unfortunately, because of the restrictions of the CON law, we have lost several physicians in Fairbanks. In reality, the hospitals, with the aid of the CON law, play a significant role in the shortage of physicians in Alaska.

Yet, Fairbanks Memorial Hospital continues to portray the community hospital image with their "People First" ad which they state is the definition of a community hospital. They go on to say that "a community hospital means that regardless of ability to pay you always have access to the finest health care available." This may be true but very deceiving.

What they don't reveal is if you are unable pay your bill in a timely manner you will be referred to NorthRim Bank to obtain a loan with interest to pay your account. If you are unable to pay this account the hospital will turn you over to collections. I have witnessed patients and our staff members who have been threatened and turned over to collections for not being able to pay their debt in a timely manner.

They also deceive the public stating their goal is to recruit physicians in Fairbanks. Not only has Fairbanks Memorial Hospital and the CON law made recruitment of physicians almost impossible they have caused physicians to close their practices and leave Fairbanks. It is well known that Fairbanks Memorial Hospital has denied hospital privileges to highly respected qualified board certified physicians. This selective restrictions has forced these particular physicians to transfer their patients to Anchorage for treatment where they have been granted hospital privileges.

Yet, Fairbanks Memorial Hospital continues to recruit and hire physicians with large bonuses. Along with the purchase of TVC and employment of their physicians they continue to grow like a cancer consuming and controlling the private sector and the community health care. This trend is alarming and should alarm everyone. <u>This trend has the earmarks of an out of control corrupt monopoly</u>.

I would like to reference a few publications by experts who have made a study of CON law and its effects on society.

The first is titled "<u>CON Hinders Health Care Innovations</u>" by Michael Morrisey (Professor of Health Economics at UAB School of Public Health; (morrisey@uab.edu) and Michael Ciamarra (Vice President of Alabama Policy Institute; (michaelc@alabamapolicy.org).

What the article stated, and I feel it is extremely important; is entrepreneurs and innovators are developing new ways to deliver health care which is more convenient, high in quality and less costly than currently available health services.

The level of scientific knowledge that will be discovered over the next 25 years will be four to seven times greater than the past 25 years, and we can expect dramatic breakthroughs and discoveries in health care which will stagger the imagination.

However, the article followed up with this comment. "Unfortunately, bureaucratic relics of the past often stand in the way of developing a 21st century, intelligent healthcare systems."

The article went on to say; "The regulatory agencies that provide protection from market competition and thereby offer the <u>potential for substantial profits are tempting targets for unscrupulous politicians, bureaucrats and businesses</u>."

As we all know, power can cause corruption and absolute power corrupts absolutely.

- **As referenced in the article "Corruption Trials are Painful, but Necessary to Restore Government" by Sen. Gene Therriault. Who stated: "as difficult as this is, it is necessary to begin restoring confidence in the Legislature".**

- **I concur and also believe our CON law and its beneficiaries need to be equally scrutinized and changes made to restore integrity in the health care system. This will also be painful, but necessary.**

- **We need to have honest hearings and honest discussions with professional input on the floors of the Senate and House to look at the special interests and the present health care monopoly in our health care system under the protection of the CON law.**

This article went on to say the CON provides less choice and less innovation and the CON program has never controlled costs and has become a mechanism to limit competition in health care, making all of us worse off.

- **This was not the original intent of the CON law.**

- **The CON process stops growth and new providers find themselves tied up with costly CON hearings with appeals.**

- **This unfortunately, is certainly what we have experienced here in Fairbanks Alaska.**

The article also stated; consumers don't save money with the CON program. Currently, hospitals and other protected providers argue that CON keeps new providers from coming in and taking the profitable patients. They agree this is a possibility.

- **We often hear the term "Cherry Picking" by those individuals defending the CON law.**

However, the article then stated; the existing providers and hospitals are collecting fees which are higher than their costs and probably higher than the new entrants would charge. <u>So, by their own admission, these providers and hospitals are charging higher fees</u>.

The article then stated; "What is amazing, there is virtually <u>no empirical evidence</u> that the CON program has been effective in reducing hospital or health-care costs and <u>some evidence that it increases costs</u>".

Another extremely important point the article brought out was; "The evidence also shows that the elimination of the CON law HAS NOT caused any harm to incumbent hospitals".

- **The fact is hospitals responded to the competition by delivering better care.**

- **The elimination of the CON actually improved the health care with higher quality and lower cost in the marketplace.**

In summary, the article stated: "The CON should be tossed into the dump heap and that it is time for the Legislature to dismantle CON completely".

Contrary to the scare tactics used by pro-con advocates and claims the elimination of the CON caused closures of hospitals in Oklahoma, which is a fabrication of the truth. It is well documented these referenced hospital closures were mergers with other hospitals and had absolutely nothing to do with the elimination of the CON. There is no documented evidence that the elimination of the CON has caused any hospital closures. In fact, as previously noted there is no evidence the elimination of the CON as even caused any harm to incumbent hospitals.

Furthermore, the Medicare Payment Advisory Commission has determined that specialty hospitals do not undercut the financial stability of community hospitals. Neither will ambulatory surgery centers. This Advisory Commission stated the current CON law gives hospitals a monopoly. They also stated there is no evidence showing a community hospital being forced to close as a result of competition from an ambulatory surgery center.

My personal thoughts are: (and I believe this is very important).

- **If the hospitals need protection to stay functioning they are not providing customer service or adequately serving the community.**
- **If these hospitals are truly user friendly, serving the community, and providing quality health care they have absolutely nothing to worry about, and should welcome growth and innovation in our community and in health care.**

- **If, in fact, certain hospitals are not providing these services they need to change their way of doing business and refocus their priorities and customer service.**

- **My question is - when is it the state governments' responsibility to protect and bail out big business?**

In reality, the public, your constitutes, are the ones that need your protection and support, not big business or special interests.

The next article I would like to reference is on the antitrust perspective. On February 23, 2007 Mark Botti, (Chief Litigation Section, US Department of Justice, Antitrust Division) spoke on "Competition in Healthcare and Certificates of Need" before a Joint Session of the Health and Human Services Committee of the State House of Representatives in the State of Georgia

This entire presentation by the U.S. Department of Justice may be reviewed on web site: http://www.usdoj.gov/atr/public/comments/223754.htm

A summarization of this presentation is as follows:

The Antitrust Division's goal is to ensure a competitive marketplace in which the consumer will have the benefit of high quality, cost effective health care and a wide range of choices. Their overall mission is to preserve and promote competition, rather than to preserve any particular marketplace.

The Antitrust Division's experience and expertise has shown that Certificate of Need laws pose a substantial threat to the proper performance of healthcare markets. Indeed, by their very nature, CON laws create barriers to entry and expansion and thus are a ban to free markets.

The CON laws undercut consumer choice, weaken markets' ability to contain healthcare costs, and stifles innovation.

- **Here again we are readdressing patients' rights, entrepreneurship and innovation.**

- My question, has it not always been the hallmark of America to protect citizens' rights, encourage entrepreneurship, and free enterprise?

The article stated "Competition drives innovation and ultimately leads to the delivery of better healthcare systems and technology. Government intervention can undermine the ability of markets to deliver these benefits".

Furthermore, the article stated the fact that; "CON laws have been ineffective in serving its original purpose";

- **Essentially, government regulations have changed which eliminates the original justification and the need for CON law.**

- **The federal government no longer reimburses on a cost-plus basis and in 1986, Congress repealed the CON law.**
  - **This, in itself, is reason enough to eliminate the CON law in Alaska.**

  - **The only purpose the CON law now provides is protection; protection of existing hospitals and big business. This, of course, was not the original intent of the CON law.**

The conclusion of this presentation was that vigorous competition among healthcare providers promotes the delivery of high-quality, cost effective healthcare. Competition results in lower prices and broader access to health care and health insurance.

I would also like to reference an article in the Fairbanks Daily New-Miner, dated January 13, 2008. "Shortage of Physicians is a Real Health Care Crisis" by Mr. Van Allen, President of Timeline Recruiting, a physician recruiting firm based in Columbia, MO.

What the article stated was one of the major reasons for the shortage in physicians is the fact that many physicians are leaving their practice due to an increasing difficult work environment, rising cost of liability insurance, the constant threat of being sued and increasing administrative burdens.

- **With the upcoming physician shortage this author has predicted, does anyone realistically believe we can recruit and retain physicians in Alaska with the adversarial environment and health care monopoly we presently have under the protection of the CON law when we can't even retain the physicians we already have?**

Summary:

As previously stated, CON laws have been ineffective in serving their original purpose. Government regulations have changed which eliminates the original justification for the CON program.

- **CON law stifles entrepreneurship, innovations, competition, free markets, protects incumbent hospitals, eliminates consumer choices, and keeps prices and profits high.**
  - **Protects the present Health Care Monopoly.**

- **Competition breeds excellence, the lack of competition breeds mediocrity. Competition fosters entrepreneurship and innovation; it allows a wide range of choices, improves the quality of health care, access to health care and lowers the costs of healthcare services.**

- **Change is not easy: But without change there can be no improvement and growth. We must control our own destiny, not government, bureaucrats or big business. If we do not make appropriate changes to take care of our residents it is obvious other institutions will make changes for us.**

If you truly want to help provide Alaskans with quality health care, and I trust you do, a more positive and productive approach would be:

- **The elimination of the CON which would improve the work environment, and open the door for entrepreneurs and innovative ideas to improve health care, and;**

- **Assist in controlling health insurance, malpractice insurance and tort reform which would be a great start.**

I am asking you, our elected legislators, to do the right thing and represent the citizens of Alaska that elected you into office and not the special interests organizations and their lobbyists.

- **Americans and Alaskans in particular are by nature an independent and intelligent people. In general they are unwilling to accept the insidious growth and influence of government and big business impacting and controlling their private lives, including health care and the private enterprise.**

- **Let's quit beating this dead horse, and wasting our time and money. The CON law is an outdated, and abusive restrictive law which serves no viable function except protectionism and restriction of trade in a corrupt health care system. Let us get rid of it now.**

- **Progress is impossible without change. However, some things should never change, this being the values and integrity and belief in people to do what is right. In other words, live and lead by the golden rule. We are all here to serve, to serve the public in our own ways and professions.**

- **We need to get away from this scarcity mentality and protectionism and have more of abundance mentality, and a positive futuristic approach with our health care. We need to focus on what we can do, not on what we can't do.**

Governor Palin has shown the foresight, courage and leadership in her quest to eliminate the CON law in Alaska. I am asking for your support and assistance to eliminate the CON law in Alaska.

Sincerely,

Stephen H. Sutley, DDS, MA

cc: Governor Palin
Senators and Representatives

ASHNHA

Alaska State Hospital and Nursing Home Association

2008 Alaska Hospital Community Benefits Report

Alaska's Hospitals Creating Healthier Communities

ALASKA'S HOSPITALS:
IMPROVING HEALTH THROUGH COMMUNITY BENEFITS

About this Report

The challenges to improving the health of Alaskans are as tall as our mountains and as unique as our topography, climates and communities. Each and every day, Alaska hospitals voluntarily offer programs and services in their communities that exceed traditional daily medical care. These programs and services — called Community Benefits — deliver health care assistance and solutions to specific populations with unique medical needs. The goal of Community Benefits is to improve the health of Alaska by improving the quality of life for Alaskans.

The Alaska State Hospital and Nursing Home Association (ASHNHA) is proud to present the *2008 Alaska Hospital Community Benefits Report*. While many people are familiar with hospitals' role as major employers, this is the first time ASHNHA has quantified and reported to Alaskans the Community Benefits provided by the state's acute care hospitals.

Community Benefits are programs and services that exceed the routine and emergency care provided around the clock daily by Alaska hospitals. Community Benefits are often provided free of charge or at substantially reduced fees. They are targeted programs and services that address the identified and often unique health care, social and welfare needs of the people who live in a particular community. These benefits provide measurable improvements in health status and access to health care for a community's residents. They also provide care to Alaskans regardless of ability to pay.

Sixteen Alaskan hospitals provided data to the *2008 Alaska Hospital Community Benefits Report*. Participating hospitals are Alaska Regional Hospital, Anchorage; Bartlett Regional Hospital, Juneau; Central Peninsula Hospital, Soldotna; Cordova Community Medical Center, Cordova; Fairbanks Memorial Hospital, Fairbanks; Ketchikan General Hospital, Ketchikan; Mat-Su Regional Medical Center, Palmer; North Star Behavioral Health, Anchorage; Petersburg Medical Center, Petersburg; Sitka Community Hospital, Sitka; South Peninsula Hospital, Homer; Wrangell Medical Center, Wrangell; Providence Alaska Medical Center, Anchorage; Providence Kodiak Island Medical Center, Kodiak; Providence Seward Medical & Care Center, Seward; and Providence Valdez Medical Center, Valdez.

COMMUNITY BENEFITS: SAVING & CHANGING LIVES

Safe Kids Water Safety Program Saves Lives

Dan Baeten credits his 14-year-old son for saving the lives of his family members after attending the Safe Kids Water Safety community benefit event in Soldotna. The young man's personal flotation device and his knowledge of how to handle a boating accident saved the family when their canoes overturned and were swept down river on a treacherous stretch of water.

WOW Ride Gives Back

Oncology nurse Kathy Lopeman started a fun-filled winter snowmobile fundraiser. The event raised $34,000 to distribute to community members as $1,000 grants for those needing items not covered by insurance or assistance to travel for medical care.

FINDINGS:

ALASKA HOSPITALS PROVIDE $151.6 MILLION IN COMMUNITY BENEFITS

Alaska hospitals provided $151.6 million in Community Benefits to communities and citizens in 2006, the most recent year for which data are available. The hospitals also paid more than $10.3 million in taxes and fees to state and local governments. The data come from surveys completed in January 2008 by 16 Alaska hospitals (see complete list on page 2 under "About this Report.") Community Benefits are programs and services offered by hospitals beyond required daily health care services. They target specific populations in a community with assistance and solutions to unique health care needs.

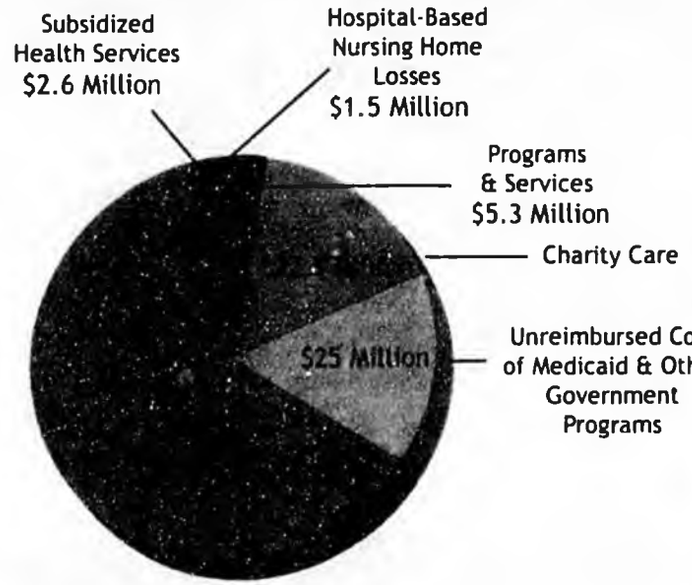
ASHNHA Community Benefits Survey Report Summary

Benefit Category	*Participants Served*	*Loss/Cost*
Community Health Improvement Services		
Community Health Education	57,394	$1,340,996
Support Groups	128	$2,798
Self Help	242	$1,900
Nonbilled/Reduced-Fee Clinics	7,016	$142,434
Health Screening	989	$49,494
Immunization	800	$18,807
Counseling	424	$76,755
Family Support Services	15	$2,120
Free/Discounted Prescriptions/Supplies to Patients	473	$75,512
In-Home Services	307	$1,060
Meals/Nutrition Services	5,382	$212,469
Transportation Services	628	$38,314
All Other Health Care Support Services	75	$500
Community Health Improvement Services Total	**73,873**	**$1,963,159**
Financial and In-Kind Contributions	**15,730**	**$1,214,786**
Health Professions Education Contribution	**1,247**	**$2,044,967**
Health Research Contribution	**0**	**0**
Community Building Activities	**16,046**	**$79,375**
Community Benefit Operations	**0**	**$3,700**
TOTAL PARTICIPANTS IN COMMUNITY BENEFITS PROGRAMS		**106,896**
Charity Care At Cost		**$22,967,322**
Medicaid Underpayment		**$12,545,792**
Losses on Other Public Programs (Excludes Medicare and Medicaid)		**$12,543,156**
Bad Debt at Cost		**$37,198,890**
Medicare Unreimbursed		**$56,830,190**
Subsidized Health Services		**$2,664,408**
Hospital-Based Nursing Home Losses		**$1,501,816**
TOTAL COMMUNITY BENEFITS		**$151,557,561**

Community Benefits Improve the Health of Thousands of Alaskans

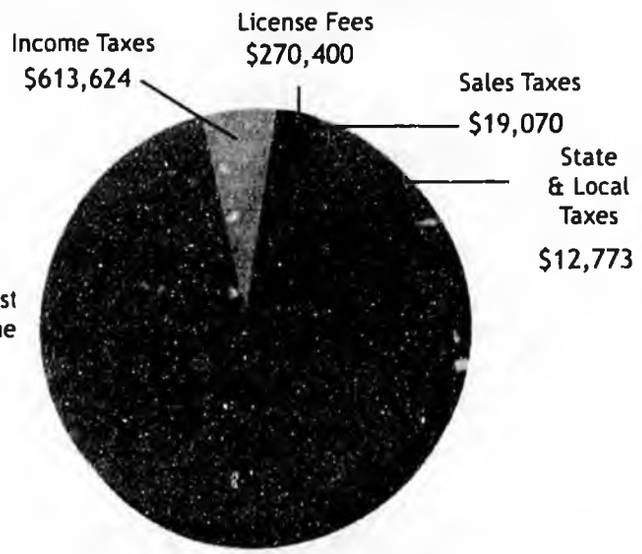
This report uses numbers to present the Community Benefits provided by Alaska hospitals. But Community Benefits are really about people. Community Benefits include care provided free of charge to Alaskans who are unable to pay. Programs and services can include prenatal care for expectant mothers and families, smoking cessation, preventing sports and other avoidable injuries, CPR and first aid classes, AIDS education and awareness, school-based health services, help for elderly citizens, work-site based health promotion, fitness and exercise seminars, blood pressure screenings, cholesterol testing, mental health and depression screenings, diabetes counseling, adult and child immunizations, blood drives, nutrition and weight loss management, substance abuse counseling, prescription drugs, transportation services, child car safety seat classes, and so much more. The goal of Community Benefits is to improve the health of Alaska by improving the quality of life for Alaskans.

Alaska Hospitals Provide $151.6 Million in Community Benefits



Total Value of Benefits Provided to Alaskan Communities: $151.55 Million

Alaska Hospitals Send $10.3 Million in Taxes, Fees to State and Local Governments



Total Payments to State and Local Governments: $10.31 Million

ASHNHA
Alaska State Hospital and Nursing Home Association
420 Main Street • Juneau, Alaska 99801
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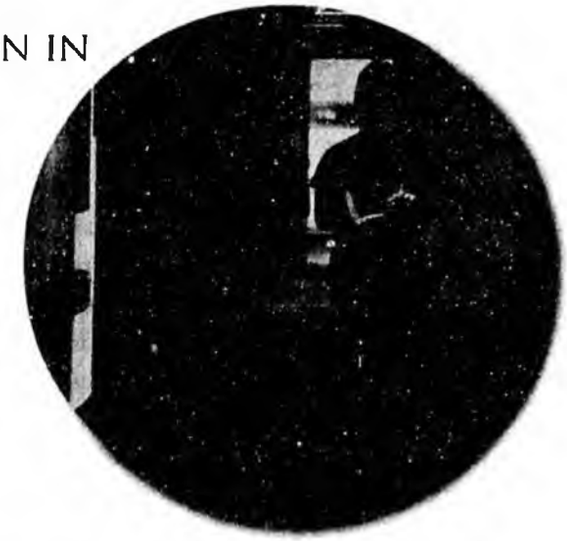
FINDINGS:

ALASKA HOSPITALS PROVIDE $151.6 MILLION IN COMMUNITY BENEFITS



Alaska hospitals provided $151.6 million in Community Benefits to communities and citizens in 2006, the most recent year for which data are available. The hospitals also paid more than $10.3 million in taxes and fees to state and local governments. The data come from surveys completed in January 2008 by 16 Alaska hospitals (see complete list on page 2 under "About this Report.") Community Benefits are programs and services offered by hospitals beyond required daily health care services. They target specific populations in a community with assistance and solutions to unique health care needs.

ASHNHA Community Benefits Survey Report Summary

Benefit Category	*Participants Served*	*Loss/Cost*
Community Health Improvement Services		
Community Health Education	57,394	$1,340,996
Support Groups	128	$2,798
Self Help	242	$1,900
Nonbilled/Reduced-Fee Clinics	7,016	$142,434
Health Screening	989	$49,494
Immunization	800	$18,807
Counseling	424	$76,755
Family Support Services	15	$2,120
Free/Discounted Prescriptions/Supplies to Patients	473	$75,512
In-Home Services	307	$1,060
Meals/Nutrition Services	5,382	$212,469
Transportation Services	628	$38,314
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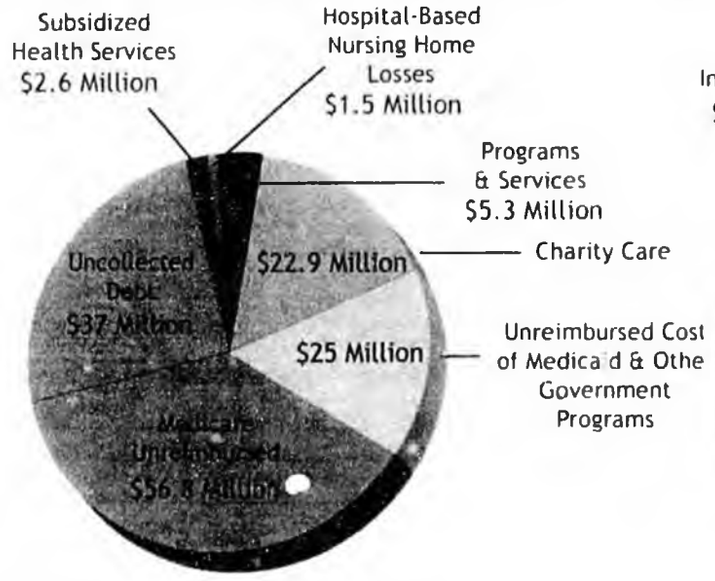
Alaska Hospitals Provide $151.6 Million in Community Benefits



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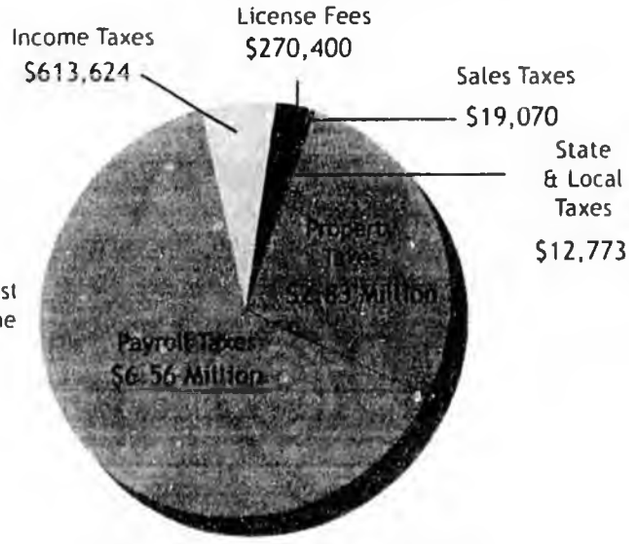

Total Payments to State and Local Governments: $10.31 Million