SB

245

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/08

FURTHER: (Finance)

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/31/08

Health, Education and Social Services Committee considered

SENATE BILL NO. 245

SB 245 HEALTH CARE: PLAN/COMMISSION/FACILITIES

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date."

and recommends:

[✓] be **replaced** with [ ] **SCS** or [✓] **CS** SB 245 (HES)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[✓] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department					
DHSS/2077	3/28/08			✓	
DHSS/2766	3/28/08	✓			
DHSS/317	3/28/08			✓	
	?				

PREVIOUS FISCAL NOTE(S):

					FN#
HSS	1/17/08	✓			2
HSS	1/18	✓			3

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS		DO PASS	DO NOT PASS	NO REC	AMEND
	Elton			✓	
	Thomas	✓			
	Dyson			✓	
	Coghill		✓		
CHAIR:	DAVIS	✓			

Alaska State Legislature

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Senator_Bettye_Davis@legis.state.ak.us
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Senator Bettye Davis
Senate HESS Committee

Senate Bill No. 245
"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date."

Work Drafts

02/11/08
GS2050\L - Senate CS amending "K" version with changes
2/08/08
GS2050K - Senate CS amending "M" version with changes
2/5/08
25-GS2050\M – Senate CS amending "E" version and adding 2 more public members
2/1/08
25-GS2050\E - Senate CS incorporating House composition of Commission
1/29/08
25-GS2050\C – Senate CS to incorporate Governor's Amendments
1/25/08
Staff Memo, Senator Davis - regarding summary of Governor's Bill
1/19/08
25-GS2050\A – Governor's Bill with Amendments, Sectional Analysis and Fiscal Notes
1/30/08
25-GH2050\E - CS for House Bill 337(HES) with notes from HSS

25-GS2050\K
Mischel
2/8/08

CS FOR SENATE BILL NO. 245( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; relating to and repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health

issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers,

within the public health system to achieve the mission of public health.

*** Sec. 2.** AS 18.07.111(8) is amended to read:

(8) "health care facility"

definition of a healthcare facility

(A) means

(i) a nursing home; or

(ii) a facility that is located in a community in which a hospital is designated by the department as a critical access hospital and that is a 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, [(] including freestanding hemodialysis units [)], intermediate care facility, and ambulatory surgical facility;

(B) does not include [THE TERM EXCLUDES]

(i) [(A)] the Alaska Pioneers' Home and the Alaska Veterans' Home administered by the Department of Health and Social Services under AS 47.55; and

(ii) [(B)] the offices of private physicians or dentists whether in individual or group practice;

*** Sec. 3.** AS 18.07.111 is amended by adding new paragraphs to read:

(11) "critical access hospital" means a facility that is a hospital licensed in the state that satisfies the criteria set out in 42 U.S.C. 1395i-4(e)(2)(B) (Social Security Act) and meets the conditions of participation set out in 42 C.F.R. 485.601 – 485.647;

(12) "nursing home" means a nursing facility as defined in 42 U.S.C. 1396r(a) (Social Security Act).

*** Sec. 4.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care Planning and Information.

Article 1. Alaska Health Care Commission; State Health Plan.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The

[DELETED TEXT BRACKETED]

purposes of the commission are

(1) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state; and

(2) to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Sec. 18.09.020. Composition; chair. (a) The commission consists of 12 members as follows:

(1) the state officer assigned the duties of medical director for the department;

(2) one member representing the Department of Administration, appointed by the commissioner of administration;

(3) one member representing the Department of Commerce, Community, and Economic Development, appointed by the commissioner of commerce, community, and economic development;

(4) one member representing the Department of Labor and Workforce Development, appointed by the commissioner of labor and workforce development;

(5) five public members, appointed by the governor; one of the members appointed under this paragraph must be a small business owner in the state;

(6) one ex officio nonvoting member from the house of representatives, appointed by the speaker of the house;

(7) one ex officio nonvoting member from the senate, appointed by the president of the senate; and

(8) one ex officio nonvoting member representing the Office of the Governor.

(b) The department's representative appointed under (a)(1) of this section shall serve as chair of the commission.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(a)(5) serve for staggered terms of three years.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) The governor may remove a public member of the commission from office only for cause.

Sec. 18.09.040. Executive director. The commission shall employ an executive director who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing proceedings and other activities, including provisions concerning a quorum to transact commission business and other aspects of procedure; frequency and location of meetings; and establishment, functions, and membership of committees.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for

(A) encouraging personal responsibility in prevention and healthy living for all residents of the state;

(B) reducing health care costs for all residents of the state to below the national average;

(C) ensuring access in communities to safe water and wastewater systems;

(D) developing a sustainable health care workforce in the state;

(E) ensuring access to quality health care for all residents of the state; and

(F) increasing the number of residents of the state who are

covered by insurance for health care services.

(b) The commission shall review and approve health care information for placement on the department's database developed under AS 18.09.110.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities.

Sec. 18.09.080. Compensation, per diem, and expenses. A public member appointed to the commission under AS 18.09.020(a)(5) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

Article 2. Alaska Health Care Information Office.

Sec. 18.09.100. Office. The Alaska health care information office is established in the department. The purpose of the office is to improve access by residents of the state to consistently updated

(1) information about health care facilities to aid consumers of health care services of health care facilities in the state; and

(2) information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110. Dissemination of information. (a) The department shall establish and maintain an information database on the Internet of information about all health care facilities in the state to provide objective, unbiased, and factually based information on health care facilities in the state. The department may require those health care facilities to provide information in a standard form or format to the department for placement in the database. Before information is placed on the database, the commission shall review the information for accuracy.

(b) The database developed under (a) of this section must include the following

(1) a list of preferred drugs approved by the department for reimbursement by the department;

(2) a complete list, organized by region and address, of

(A) health facilities located in the state;

(B) licensed pharmacists and pharmacies located in the state;

(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state;

(G) public assistance offices of the department;

(3) a list of the 100 most commonly prescribed medications in the state and the source and price, updated monthly, of the medications;

(4) a list of the 100 most commonly conducted medical procedures in the state, organized by the cash and negotiated price of the procedure at available providers and insurers, updated annually; the list must include medical procedures covered by workers' compensation under AS 23.30;

(5) available hospital ratings, including the rates of hospital acquired infections and mortality occurring at each hospital located in the state;

(6) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, that includes the location of available sites that provide care and treatment related to those issues;

(7) a list of procedures approved by state agencies for emergency response and treatment;

(8) disease management support information;

(9) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

(B) links to Internet websites for purchasing insurance policies;

(C) an explanation of mandatory and optional insurance coverage;

(10) a list of primary care clinics that cater to uninsured and self-pay

patients; and

(11) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility.

(c) The department may contract with a private entity to provide services and information required under (a) of this section.

(d) The department shall develop and consistently update an Internet website to provide residents of the state timely and accurate information regarding prevention and healthy living.

(e) The department shall post and make available information related to the commission, including the commission's annual reports under AS 18.09.070(c).

Sec. 18.09.120. Mandatory reporting. (a) A health care facility shall provide to the department the following information related to the facility's health care services for placement in the database developed under AS 18.09.110:

(1) information on costs to the consumer for health care services;

(2) types of insurance and payment accepted by the health care facility for health care services;

(3) each location where the health care facility operates, and the hours of operation;

(4) the types and scope of health care services offered at the health care facility;

(5) the Internet address of any Internet website of the health care facility the purpose of which is to provide factual information to aid the consumer;

(6) any other readily accessible information that the department determines would help the consumer to make informed decisions about the health care facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of a failure to report under (a) of this section and give the health care facility an opportunity to contest or cure the failure. If the health care facility does not promptly cure the failure, the department shall post the notice of failure on the database developed under AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide to the commission for placement on the database developed under AS 18.09.110 information regarding an adverse action taken against a health care facility in the state or against a licensed professional practicing in a health care facility in the state; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "costs to the consumer" means actual price paid by the consumer for health care services;

(3) "department" means the Department of Health and Social Services;

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing services in the state;

(C) a provider of a home and community based waiver service that is certified under regulations adopted by the department;

(D) a provider of personal care services that is certified under regulations adopted by the department.

*** Sec. 5.** AS 18.26.220 is amended to read:

Sec. 18.26.220. Facility compliance with health and safety laws and licensing requirements. A medical facility constructed, acquired, improved, financed, or otherwise under the provisions of this chapter and all actions of the authority are subject to [AS 18.07,] AS 47.32 [,] and any other present or future state licensing requirements for the facilities or services provided under this chapter. [A MEDICAL FACILITY ISSUED A CERTIFICATE OF NEED UNDER SEC. 4, CH. 275, SLA 1976, BY VIRTUE OF BEING IN EXISTENCE OR UNDER CONSTRUCTION BEFORE JULY 1, 1976, MUST FULLY MEET THE REQUIREMENTS OF AS 18.07 IN ORDER TO BE ELIGIBLE FOR FUNDING UNDER THIS CHAPTER.]

*** Sec. 6.** AS 21.86.030(e) is amended to read:

(e) Nothing in this section relieves a health maintenance organization that wishes to exercise the power described in (a)(1) of this section from the requirements of

(1) [AS 18.07, REGARDING OBTAINING A CERTIFICATE OF NEED;

(2)] AS 47.32, regarding regulation of hospitals; and

(2) [(3)] other statutes applicable to hospitals or other health care facilities.

*** Sec. 7.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

*** Sec. 8.** AS 18.07.021, 18.07.031, 18.07.035, 18.07.041, 18.07.043, 18.07.045, 18.07.051, 18.07.061, 18.07.071, 18.07.081, 18.07.091, 18.07.101, 18.07.111; and AS 47.80.140(b) are repealed.

*** Sec. 9.** (a) The following regulations are annulled:

(1) 7 AAC 07.010, 7 AAC 07.012, 7 AAC 07.015, 7 AAC 07.025, 7 AAC 07.031, 7 AAC 07.032, 7 AAC 07.033, 7 AAC 07.035, 7 AAC 07.040, 7 AAC 07.042, 7 AAC 07.050, 7 AAC 07.052, 7 AAC 07.060, 7 AAC 07.067, 7 AAC 07.070, 7 AAC 07.072, 7 AAC 07.079, 7 AAC 07.080, 7 AAC 07.092, 7 AAC 07.095, 7 AAC 07.105, 7 AAC 07.107, and 7 AAC 07.900;

(2) 7 AAC 09.030(3) and 7 AAC 09.170(5);

(3) 7 AAC 43.689(g)(4)(B);

(4) 15 AAC 118.020(c)(3) and (d)(1).

(b) The commissioner of health and social services shall immediately proceed under AS 44.62 to amend or annul the following regulations in accordance with the provisions of this Act:

(1) 7 AAC 09.020;

(2) 7 AAC 43.679, 7 AAC 43.685, 7 AAC 43.686, and 7 AAC 43.709.

*** Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: PENDING APPLICATIONS, ADMINISTRATIVE APPEALS, AND COURT ACTIONS FOR THE CERTIFICATE OF NEED PROGRAM. The commissioner of health and social services through the Department of Law shall immediately take steps to seek

dismissal of pending administrative appeals and court actions concerning the issuance of certificates of need, as appropriate, under AS 18.07, as amended by secs. 2 and 3 of this Act or implementation of AS 18.07.

*** Sec. 11.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: PENDING APPLICATIONS, ADMINISTRATIVE APPEALS, AND COURT ACTIONS FOR THE CERTIFICATE OF NEED PROGRAM. (a) The commissioner of health and social services through the Department of Law shall immediately take steps to seek dismissal of pending administrative appeals and court actions concerning the issuance of certificates of need under AS 18.07 or implementation of AS 18.07.

(b) The Department of Health and Social Services shall immediately close all pending application files under AS 18.07. The Department of Health and Social Services shall send written notification to applicants of the action taken under this subsection.

*** Sec. 12.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 13.** Sections 5, 6, 8, 9, and 11 of this Act take effect July 1, 2010.

*** Sec. 14.** Except as provided in sec. 13 of this Act, this Act takes effect July 1, 2008.

25-GS2050\M
Mischel
2/5/08

CS FOR SENATE BILL NO. 245( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health

New Text Underlined [DELETED TEXT BRACKETED]

issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers,

within the public health system to achieve the mission of public health.

*** Sec. 2.** AS 18.07.111(8) is repealed and reenacted to read:

(8) "health care facility" means a private, municipal, state, or federal hospital that has been designated by the department as a critical access hospital.

*** Sec. 3.** AS 18.07.111 is amended by adding new paragraphs to read:

(11) "critical access hospital" means a facility that is a hospital licensed in the state that satisfies the criteria set out in 42 U.S.C. 1395i-4(c)(2)(B) (Social Security Act) and meets the conditions of participation set out in 42 C.F.R. 485.601 - 485.647;

(12) "nursing home" means a nursing facility as defined in 42 U.S.C. 1396r(a) (Social Security Act).

*** Sec. 4.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care Planning and Information.

Article 1. Alaska Health Care Commission; State Health Plan.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purposes of the commission are

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(2) to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Sec. 18.09.020. Composition; chair. (a) The commission consists of 12 members as follows:

(1) the state officer assigned the duties of medical director for the department;

(2) one member representing the Department of Administration, appointed by the commissioner of administration;

(3) one member representing the Department of Commerce, Community, and Economic Development, appointed by the commissioner of commerce, community, and economic development;

New Text Underlined [DELETED TEXT BRACKETED]

(4) one member representing the Department of Labor and Workforce Development, appointed by the commissioner of labor and workforce development;

(5) five public members, appointed by the governor; one of the members appointed under this paragraph must be a small business owner in the state;

(6) one ex officio nonvoting member from the house of representatives, appointed by the speaker of the house;

(7) one ex officio nonvoting member from the senate, appointed by the president of the senate; and

(8) one ex officio nonvoting member representing the Office of the Governor.

(b) The department's representative appointed under (a)(1) of this section shall serve as chair of the commission.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(a)(5) serve for staggered terms of three years.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

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Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

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(A) encouraging personal responsibility in prevention and healthy living for all residents of the state;

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(D) developing a sustainable health care workforce in the state;

(E) ensuring access to quality health care for all residents of the state; and

(F) increasing the number of residents of the state who are covered by insurance for health care services.

(b) The commission shall review and approve health care information for placement on the department's database developed under AS 18.09.110.

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Sec. 18.09.080. Compensation, per diem, and expenses. A public member appointed to the commission under AS 18.09.020(a)(5) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

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(1) information about health care facilities to aid consumers of health

care services of health care facilities in the state; and

(2) information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110. Dissemination of information. (a) The department shall establish and maintain an information database on the Internet of information about all health care facilities in the state to provide objective, unbiased, and factually based information on health care facilities in the state. The department may require those health care facilities to provide information in a standard form or format to the department for placement in the database. Before information is placed on the database, the commission shall review the information for accuracy.

(b) The database developed under (a) of this section must include the following:

(1) a list of preferred drugs approved by the department for reimbursement by the department;

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(A) health facilities located in the state;

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(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state;

(G) public assistance offices of the department;

(3) a list of the 100 most commonly prescribed medications in the state and the source and price, updated monthly, of the medications;

(4) a list of the 100 most commonly conducted medical procedures in the state, organized by the cash and negotiated price of the procedure at available providers and insurers, updated annually; the list must include medical procedures covered by workers' compensation under AS 23.30;

(5) available hospital ratings, including the rates of hospital acquired infections and mortality occurring at each hospital located in the state;

(6) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, that includes the location of available sites that provide care and treatment related to those issues;

(7) a list of procedures approved by state agencies for emergency response and treatment;

(8) disease management support information;

(9) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

(B) links to Internet websites for purchasing insurance policies;

(C) an explanation of mandatory and optional insurance coverage;

(10) a list of primary care clinics that cater to uninsured and self-pay patients; and

(11) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility.

(c) The department may contract with a private entity to provide services and information required under (a) of this section.

(d) The department shall develop and consistently update an Internet website to provide residents of the state timely and accurate information regarding prevention and healthy living.

(e) The department shall post and make available information related to the commission, including the commission's annual reports under AS 18.09.070(c).

Sec. 18.09.120. Mandatory reporting. (a) A health care facility shall provide to the department the following information related to the facility's health care services for placement in the database developed under AS 18.09.110:

(1) information on costs to the consumer for health care services;

(2) types of insurance and payment accepted by the health care facility for health care services;

(3) each location where the health care facility operates, and the hours of operation;

(4) the types and scope of health care services offered at the health care facility;

(5) the Internet address of any Internet website of the health care facility the purpose of which is to provide factual information to aid the consumer;

(6) any other readily accessible information that the department determines would help the consumer to make informed decisions about the health care facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of a failure to report under (a) of this section and give the health care facility an opportunity to contest or cure the failure. If the health care facility does not promptly cure the failure, the department shall post the notice of failure on the database developed under AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide to the commission for placement on the database developed under AS 18.09.110 information regarding an adverse action taken against a health care facility in the state or against a licensed professional practicing in a health care facility in the state; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "costs to the consumer" means actual price paid by the consumer for health care services;

(3) "department" means the Department of Health and Social Services;

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing services in the state;

(C) a provider of a home and community based waiver service that is certified under regulations adopted by the department;

(D) a provider of personal care services that is certified under regulations adopted by the department.

* **Sec. 5.** AS 18.26.220 is amended to read:

Sec. 18.26.220. Facility compliance with health and safety laws and licensing requirements. A medical facility constructed, acquired, improved, financed, or otherwise under the provisions of this chapter and all actions of the authority are subject to [AS 18.07,] AS 47.32 [,] and any other present or future state licensing requirements for the facilities or services provided under this chapter. [A MEDICAL FACILITY ISSUED A CERTIFICATE OF NEED UNDER SEC. 4, CH. 275, SLA 1976, BY VIRTUE OF BEING IN EXISTENCE OR UNDER CONSTRUCTION BEFORE JULY 1, 1976, MUST FULLY MEET THE REQUIREMENTS OF AS 18.07 IN ORDER TO BE ELIGIBLE FOR FUNDING UNDER THIS CHAPTER.]

* **Sec. 6.** AS 21.86.030(c) is amended to read:

(c) Nothing in this section relieves a health maintenance organization that wishes to exercise the power described in (a)(1) of this section from the requirements of

New Text Underlined [DELETED TEXT BRACKETED]

(1) [AS 18.07, REGARDING OBTAINING A CERTIFICATE OF NEED;

(2)] AS 47.32, regarding regulation of hospitals; and

(2) [(3)] other statutes applicable to hospitals or other health care facilities.

*** Sec. 7.** AS 39.25.120(e)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

*** Sec. 8.** AS 18.07.021, 18.07.031, 18.07.035, 18.07.041, 18.07.043, 18.07.045, 18.07.051, 18.07.061, 18.07.071, 18.07.081, 18.07.091, 18.07.101, 18.07.111; and AS 47.80.140(b) are repealed.

*** Sec. 9.** (a) The following regulations are annulled:

(1) 7 AAC 07.010, 7 AAC 07.012, 7 AAC 07.015, 7 AAC 07.025, 7 AAC 07.031, 7 AAC 07.032, 7 AAC 07.033, 7 AAC 07.035, 7 AAC 07.040, 7 AAC 07.042, 7

AAC 07.050, 7 AAC 07.052, 7 AAC 07.060, 7 AAC 07.067, 7 AAC 07.070, 7 AAC 07.072, 7 AAC 07.079, 7 AAC 07.080, 7 AAC 07.092, 7 AAC 07.095, 7 AAC 07.105, 7 AAC 07.107, and 7 AAC 07.900;

(2) 7 AAC 09.030(3) and 7 AAC 09.170(5);

(3) 7 AAC 43.689(g)(4)(B);

(4) 15 AAC 118.020(c)(3) and (d)(1).

(b) The commissioner of health and social services shall immediately proceed under AS 44.62 to amend or annul the following regulations in accordance with the provisions of this Act:

(1) 7 AAC 09.020;

(2) 7 AAC 43.679, 7 AAC 43.685, 7 AAC 43.686, and 7 AAC 43.709.

* **Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: PENDING APPLICATIONS, ADMINISTRATIVE APPEALS, AND COURT ACTIONS FOR THE CERTIFICATE OF NEED PROGRAM. (a) The commissioner of health and social services through the Department of Law shall immediately take steps to seek dismissal of pending administrative appeals and court actions concerning the issuance of certificates of need under AS 18.07 or implementation of AS 18.07.

(b) The Department of Health and Social Services shall immediately close all pending application files under AS 18.07. The Department of Health and Social Services shall send written notification to applicants of the action taken under this subsection.

* **Sec. 11.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

* **Sec. 12.** Sections 5, 6, and 8 - 10 of this Act take effect July 1, 2010.

* **Sec. 13.** Except as provided in sec. 12 of this Act, this Act takes effect July 1, 2008.

LEGAL SERVICES

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

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

MEMORANDUM February 5, 2008

SUBJECT: Composition of the Alaska Health Care Commission
(CSSB 245( ), Work Order No. 25-GS2050 L)

TO: Senator Bettye Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

Enclosed is the draft CS you requested for SB 245. I wanted to alert you that removing the phrase "ex officio nonvoting" from the appointment of legislative members of the proposed Alaska Health Care Commission may create a separation of powers issue in this bill. 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 roles of the legislative or executive branch.

If I may be of further assistance, please advise.

JMM:med
08-078:med

Enclosure

25-GS2050\E
Mischel
2/1/08

CS FOR SENATE BILL NO. 245( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about

New Text Underlined [DELETED TEXT BRACKETED]

health issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including

municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

*** Sec. 2.** AS 18.07.111(8) is repealed and reenacted to read:

(8) "health care facility" means a private, municipal, state, or federal hospital that has been designated by the department as a critical access hospital.

*** Sec. 3.** AS 18.07.011 is amended by adding new paragraphs to read:

(11) "critical access hospital" means a facility that is a hospital licensed in the state that satisfies the criteria set out in 42 U.S.C. 1395i-4(c)(2)(B) (Social Security Act) and meets the conditions of participation set out in 42 C.F.R. 485.601 - 485.647;

(12) "nursing home" means a nursing facility as defined in 42 U.S.C. 1396r(a) (Social Security Act).

*** Sec. 4.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care Planning and Information.

Article 1. Alaska Health Care Commission; State Health Plan.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purposes of the commission are

(1) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state; and

(2) to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Sec. 18.09.020. Composition; chair. (a) The commission consists of 12 members as follows:

(1) the state officer assigned the duties of medical director for the department;

(2) one member representing the Department of Administration, appointed by the commissioner of administration;

(3) one member representing the Department of Commerce, Community, and Economic Development, appointed by the commissioner of

commerce, community, and economic development;

(4) one member representing the Department of Labor and Workforce Development, appointed by the commissioner of labor and workforce development;

(5) six public members, appointed by the governor; one of the members appointed under this paragraph must be a small business owner in the state;

(6) one member from the house of representatives, appointed by the speaker of the house; and

(7) one member from the senate, appointed by the president of the senate.

(b) The department's representative appointed under (a)(1) of this section shall serve as chair of the commission.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(a)(5) serve for staggered terms of three years.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) The governor may remove a public member of the commission from office only for cause.

Sec. 18.09.040. Executive director. The commission shall employ an executive director who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing proceedings and other activities, including provisions concerning a quorum to transact commission business and other aspects of procedure; frequency and location of meetings; and establishment, functions, and membership of committees.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for

(A) encouraging personal responsibility in prevention and healthy living for all residents of the state;

(B) reducing health care costs for all residents of the state to below the national average;

(C) ensuring access in communities to safe water and wastewater systems;

(D) developing a sustainable health care workforce in the state;

(E) ensuring access to quality health care for all residents of the state; and

(F) increasing the number of residents of the state who are covered by insurance for health care services.

(b) The commission shall review and approve health care information for placement on the department's database developed under AS 18.09.110.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities.

Sec. 18.09.080. Compensation, per diem, and expenses. A public member appointed to the commission under AS 18.09.020(a)(5) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

Article 2. Alaska Health Care Information Office.

Sec. 18.09.100. Office. The Alaska health care information office is established in the department. The purpose of the office is to improve access by residents of the state to consistently updated

(1) information about health care facilities to aid consumers of health care services of health care facilities in the state; and

(2) information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110. Dissemination of information. (a) The department shall establish and maintain an information database on the Internet of information about all health care facilities in the state to provide objective, unbiased, and factually based information on health care facilities in the state. The department may require those health care facilities to provide information in a standard form or format to the department for placement in the database. Before information is placed on the database, the commission shall review the information for accuracy.

(b) The database developed under (a) of this section must include the following:

(1) a list of preferred drugs approved by the department for reimbursement by the department;

(2) a complete list, organized by region and address, of

(A) health facilities located in the state;

(B) licensed pharmacists and pharmacies located in the state;

(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state;

(G) public assistance offices of the department;

(3) a list of the 100 most commonly prescribed medications in the state and the source and price, updated monthly, of the medications;

(4) a list of the 100 most commonly conducted medical procedures in the state, organized by the cash and negotiated price of the procedure at available providers and insurers, updated annually; the list must include medical procedures

covered by workers' compensation under AS 23.30;

(5) available hospital ratings, including the rates of hospital acquired infections and mortality occurring at each hospital located in the state;

(6) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, that includes the location of available sites that provide care and treatment related to those issues;

(7) a list of procedures approved by state agencies for emergency response and treatment;

(8) disease management support information;

(9) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

(B) links to Internet websites for purchasing insurance policies;

(C) an explanation of mandatory and optional insurance coverage;

(10) a list of primary care clinics that cater to uninsured and self-pay patients; and

(11) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility.

(c) The department may contract with a private entity to provide services and information required under (a) of this section.

(d) The department shall develop and consistently update an Internet website to provide residents of the state timely and accurate information regarding prevention and healthy living.

(e) The department shall post and make available information related to the commission, including the commission's annual reports under AS 18.09.070(c).

Sec. 18.09.120. Mandatory reporting. (a) A health care facility shall

provide to the department the following information related to the facility's health care services for placement in the database developed under AS 18.09.110:

(1) information on costs to the consumer for health care services;

(2) types of insurance and payment accepted by the health care facility for health care services;

(3) each location where the health care facility operates, and the hours of operation;

(4) the types and scope of health care services offered at the health care facility;

(5) the Internet address of any Internet website of the health care facility the purpose of which is to provide factual information to aid the consumer;

(6) any other readily accessible information that the department determines would help the consumer to make informed decisions about the health care facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of a failure to report under (a) of this section and give the health care facility an opportunity to contest or cure the failure. If the health care facility does not promptly cure the failure, the department shall post the notice of failure on the database developed under AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide to the commission for placement on the database developed under AS 18.09.110 information regarding an adverse action taken against a health care facility in the state or against a licensed professional practicing in a health care facility in the state; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "costs to the consumer" means actual price paid by the consumer for health care services;

(3) "department" means the Department of Health and Social Services;

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing services in the state;

(C) a provider of a home and community based waiver service that is certified under regulations adopted by the department;

(D) a provider of personal care services that is certified under regulations adopted by the department.

* **Sec. 5.** AS 18.26.220 is amended to read:

Sec. 18.26.220. Facility compliance with health and safety laws and licensing requirements. A medical facility constructed, acquired, improved, financed, or otherwise under the provisions of this chapter and all actions of the authority are subject to [AS 18.07,] AS 47.32 [,] and any other present or future state licensing requirements for the facilities or services provided under this chapter. [A MEDICAL FACILITY ISSUED A CERTIFICATE OF NEED UNDER SEC. 4, CH. 275, SLA 1976, BY VIRTUE OF BEING IN EXISTENCE OR UNDER CONSTRUCTION BEFORE JULY 1, 1976, MUST FULLY MEET THE REQUIREMENTS OF AS 18.07 IN ORDER TO BE ELIGIBLE FOR FUNDING UNDER THIS CHAPTER.]

* **Sec. 6.** AS 21.86.030(c) is amended to read:

(c) Nothing in this section relieves a health maintenance organization that wishes to exercise the power described in (a)(1) of this section from the requirements of

(1) [AS 18.07, REGARDING OBTAINING A CERTIFICATE OF NEED;

(2)] AS 47.32, regarding regulation of hospitals; and

(2) [(3)] other statutes applicable to hospitals or other health care facilities.

* **Sec. 7.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

* **Sec. 8.** AS 18.07.021, 18.07.031, 18.07.035, 18.07.041, 18.07.043, 18.07.045, 18.07.051, 18.07.061, 18.07.071, 18.07.081, 18.07.091, 18.07.101, 18.07.111; and

AS 47.80.140(b) are repealed.

*** Sec. 9.** (a) The following regulations are annulled:

(1) 7 AAC 07.010, 7 AAC 07.012, 7 AAC 07.015, 7 AAC 07.025, 7 AAC 07.031, 7 AAC 07.032, 7 AAC 07.033, 7 AAC 07.035, 7 AAC 07.040, 7 AAC 07.042, 7 AAC 07.050, 7 AAC 07.052, 7 AAC 07.060, 7 AAC 07.067, 7 AAC 07.070, 7 AAC 07.072, 7 AAC 07.079, 7 AAC 07.080, 7 AAC 07.092, 7 AAC 07.095, 7 AAC 07.105, 7 AAC 07.107, and 7 AAC 07.900;

(2) 7 AAC 09.030(3) and 7 AAC 09.170(5);

(3) 7 AAC 43.689(g)(4)(B);

(4) 15 AAC 118.020(c)(3) and (d)(1).

(b) The commissioner of health and social services shall immediately proceed under AS 44.62 to amend or annul the following regulations in accordance with the provisions of this Act:

(1) 7 AAC 09.020;

(2) 7 AAC 43.679, 7 AAC 43.685, 7 AAC 43.686, and 7 AAC 43.709.

*** Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: PENDING APPLICATIONS, ADMINISTRATIVE APPEALS, AND COURT ACTIONS FOR THE CERTIFICATE OF NEED PROGRAM. (a) The commissioner of health and social services through the Department of Law shall immediately take steps to seek dismissal of pending administrative appeals and court actions concerning the issuance of certificates of need under AS 18.07 or implementation of AS 18.07.

(b) The Department of Health and Social Services shall immediately close all pending application files under AS 18.07. The Department of Health and Social Services shall send written notification to applicants of the action taken under this subsection.

*** Sec. 11.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the

effective date of the statutory change.

* **Sec. 12.** Sections 5, 6, and 8 - 10 of this Act take effect July 1, 2010.

* **Sec. 13.** Except as provided in sec. 12 of this Act, this Act takes effect July 1, 2008.

CSSB 245

LEGAL SERVICES

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

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Juneau, Alaska 99801-1182
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MEMORANDUM January 29, 2008

SUBJECT: Explanation of CSSB 245( ) (Work Order No. 25-GS2050 C)

TO: Senator Bettye Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

Enclosed is the draft CS you requested for SB 245, pertaining to the health commission and repealing certificates of need for health care facilities. As I understand it, the supporting materials were provided to you by the Governor's office. The change requested to the definition of "health care facility" in the draft CS at page 9 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, they do not exist.

Another aspect of this draft I'd like to call to your attention is the attempt to both repeal and modify, for a two year period, the certificate of need statutes at AS 18.07 and the corresponding implementing regulations. Rather than repeal those and somehow attempt to revive them in uncodified law as presented in the material attached to this request, we simply redefined the term "health care facility" in secs. 2 and 3 of the draft for purposes of the certificate of need requirements and provided a delayed repeal of those statutes along with the annulment of the regulations at sec. 12 of this draft.

Finally, we've made several technical changes to the bill as a whole to better comply with the drafting manual and standards.

JMM:lmb
08-004.lmb

Enclosure

25-GS2050\C
Mischel
1/29/08

CS FOR SENATE BILL NO. 245( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about

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health issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including

municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

*** Sec. 2.** AS 18.07.111(8) is repealed and reenacted to read:

(8) "health care facility" means a private, municipal, state, or federal hospital that has been designated by the department as a critical access hospital;

*** Sec. 3.** AS 18.07.011 is amended by adding new paragraphs to read:

(11) "critical access hospital" means a facility that is a hospital licensed in the state that satisfies the criteria set out in 42 U.S.C. 1395i-4(c)(2)(B) (Social Security Act) and meets the conditions of participation set out in 42 C.F.R. 485.601 - 485.647;

(12) "nursing home" means a nursing facility as defined in 42 U.S.C. 1396r(a) (Social Security Act).

*** Sec. 4.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care Planning and Information.

Article 1. Alaska Health Care Commission; State Health Plan.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purposes of the commission are

(1) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state; and

(2) to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Sec. 18.09.020. Composition; chair. (a) The commission consists of 10 members as follows:

(1) the state officer assigned the duties of medical director for the department;

(2) one member representing the Department of Administration, appointed by the commissioner of administration;

(3) one member representing the Department of Commerce, Community, and Economic Development, appointed by the commissioner of

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commerce, community, and economic development;

(4) one member representing the Department of Labor and Workforce Development, appointed by the commissioner of labor and workforce development;

(5) three public members, appointed by the governor; one of the members appointed under this paragraph must be a small business owner in the state;

(6) one ex officio nonvoting member from the house of representatives, appointed by the speaker of the house; and

(7) one ex officio nonvoting member from the senate, appointed by the president of the senate;

(8) an ex officio nonvoting member representing the Office of the Governor.

(b) The department's representative appointed under (a)(1) of this section shall serve as chair of the commission.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(a)(5) serve for staggered terms of three years.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) The governor may remove a public member of the commission from office only for cause.

Sec. 18.09.040. Executive director. The commission shall employ an executive director, who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing proceedings and other activities, including provisions concerning a quorum to

transact commission business and other aspects of procedure; frequency and location of meetings; and establishment, functions, and membership of committees.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for

(A) encouraging personal responsibility in prevention and healthy living for all residents of the state;

(B) reducing health care costs for all residents of the state to below the national average;

(C) ensuring access in communities to safe water and wastewater systems;

(D) developing a sustainable health care workforce in the state;

(E) ensuring access to quality health care for all residents of the state; and

(F) increasing the number of residents of the state who are covered by insurance for health care services.

(b) The commission shall review and approve health care information for placement on the department's database developed under AS 18.09.110.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities.

Sec. 18.09.080. Compensation, per diem, and expenses. A public member appointed to the commission under AS 18.09.020(a)(5) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

Article 2. Alaska Health Care Information Office.

Sec. 18.09.100. Office. The Alaska health care information office is

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established in the department. The purpose of the office is to improve access by residents of the state to consistently updated

(1) information about health care facilities to aid consumers of health care services of health care facilities in the state; and

(2) information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110. Dissemination of information. (a) The department shall establish and maintain an information database on the Internet of information about all health care facilities in the state to provide objective, unbiased, and factually based information on health care facilities in the state. The department may require those health care facilities to provide information in a standard form or format to the department for placement in the database. Before information is placed on the database, the commission shall review the information for accuracy.

(b) The database developed under (a) of this section must include the following:

(1) a list of preferred drugs approved by the department for reimbursement by the department;

(2) a complete list, organized by region and address, of

(A) health facilities located in the state;

(B) licensed pharmacists and pharmacies located in the state;

(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state;

(G) public assistance offices of the department;

(3) a list of the 100 most commonly prescribed medications in the state and the source and price, updated monthly, of the medications;

(4) a list of the 100 most commonly conducted medical procedures in

the state, organized by the cash and negotiated price of the procedure at available providers and insurers, updated annually; the list must include medical procedures covered by workers' compensation under AS 23.30;

(5) available hospital ratings, including the rates of hospital acquired infections and mortality occurring at each hospital located in the state;

(6) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, that includes the location of available sites that provide care and treatment related to those issues;

(7) a list of procedures approved by state agencies for emergency response and treatment;

(8) disease management support information;

(9) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

(B) links to Internet websites for purchasing insurance policies;

(C) an explanation of mandatory and optional insurance coverage;

(10) a list of primary care clinics that cater to uninsured and self-pay patients; and

(11) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility.

(c) The department may contract with a private entity to provide services and information required under (a) of this section.

(d) The department shall develop and consistently update an Internet website to provide residents of the state timely and accurate information regarding prevention and healthy living.

(e) The department shall post and make available information related to the

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commission, including the commission's annual reports under AS 18.09.070(c).

Sec. 18.09.120. Mandatory reporting. (a) A health care facility shall provide to the department the following information related to the facility's health care services for placement in the database developed under AS 18.09.110:

(1) information on costs to the consumer for health care services;

(2) types of insurance and payment accepted by the health care facility for health care services;

(3) each location where the health care facility operates, and the hours of operation;

(4) the types and scope of health care services offered at the health care facility;

(5) the Internet address of any Internet website of the health care facility the purpose of which is to provide factual information to aid the consumer;

(6) any other readily accessible information that the department determines would help the consumer to make informed decisions about the health care facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of a failure to report under (a) of this section and give the health care facility an opportunity to contest or cure the failure. If the health care facility does not promptly cure the failure, the department shall post the notice of failure on the database developed under AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide to the commission for placement on the database developed under AS 18.09.110 information regarding an adverse action taken against

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a health care facility in the state or against a licensed professional practicing in a health care facility in the state; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "costs to the consumer" means actual price paid by the consumer for health care services;

(3) "department" means the Department of Health and Social Services;

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing services in the state;

(C) a provider of a home and community based waiver service that is certified under regulations adopted by the department;

(D) a provider of personal care services that is certified under regulations adopted by the department.

* **Sec. 5.** AS 18.26.220 is amended to read:

Sec. 18.26.220. Facility compliance with health and safety laws and licensing requirements. A medical facility constructed, acquired, improved, financed, or otherwise under the provisions of this chapter and all actions of the authority are subject to [AS 18.07,] AS 47.32 [,] and any other present or future state licensing requirements for the facilities or services provided under this chapter [A MEDICAL FACILITY ISSUED A CERTIFICATE OF NEED UNDER SEC. 4, CH. 275, SLA 1976, BY VIRTUE OF BEING IN EXISTENCE OR UNDER CONSTRUCTION BEFORE JULY 1, 1976, MUST FULLY MEET THE REQUIREMENTS OF AS 18.07 IN ORDER TO BE ELIGIBLE FOR FUNDING

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UNDER THIS CHAPTER.]

*** Sec. 6.** AS 21.86.030(c) is amended to read:

(c) Nothing in this section relieves a health maintenance organization that wishes to exercise the power described in (a)(1) of this section from the requirements of

(1) [AS 18.07, REGARDING OBTAINING A CERTIFICATE OF NEED;

(2)] AS 47.32, regarding regulation of hospitals; and

(2) [(3)] other statutes applicable to hospitals or other health care facilities.

*** Sec. 7.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

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*** Sec. 8.** AS 18.07.021, 18.07.031, 18.07.035, 18.07.041, 18.07.043, 18.07.045, 18.07.051, 18.07.061, 18.07.071, 18.07.081, 18.07.091, 18.07.101, 18.07.111, and AS 47.80.140(b) are repealed.

*** Sec. 9.** (a) The following regulations are annulled:

(1) 7 AAC 07.010, 7 AAC 07.012, 7 AAC 07.015, 7 AAC 07.025, 7 AAC 07.031, 7 AAC 07.032, 7 AAC 07.033, 7 AAC 07.035, 7 AAC 07.040, 7 AAC 07.042, 7 AAC 07.050, 7 AAC 07.052, 7 AAC 07.060, 7 AAC 07.067, 7 AAC 07.070, 7 AAC 07.072, 7 AAC 07.079, 7 AAC 07.080, 7 AAC 07.092, 7 AAC 07.095, 7 AAC 07.105, 7 AAC 07.107, and 7 AAC 07.900;

(2) 7 AAC 09.030(3) and 7 AAC 09.170(5);

(3) 7 AAC 43.689(g)(4)(B);

(4) 15 AAC 118.020(c)(3) and (d)(1).

(b) The commissioner of health and social services shall immediately proceed under AS 44.62 to amend or annul the following regulations in accordance with the provisions of this Act:

(1) 7 AAC 09.020;

(2) 7 AAC 43.679, 7 AAC 43.685, 7 AAC 43.686, and 7 AAC 43.709.

*** Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: PENDING APPLICATIONS, ADMINISTRATIVE APPEALS, AND COURT ACTIONS FOR THE CERTIFICATE OF NEED PROGRAM. (a) The commissioner of health and social services through the Department of Law shall immediately take steps to seek dismissal of pending administrative appeals and court actions concerning the issuance of certificates of need under AS 18.07 or implementation of AS 18.07.

(b) The Department of Health and Social Services shall immediately close all pending application files under AS 18.07. The Department of Health and Social Services shall send written notification to applicants of the action taken under this subsection.

*** Sec. 11.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services

[NEW TEXT UNDERLINED; DELETED TEXT BRACKETED]

may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 12.** Sections 5, 6, and 8 - 10 of this Act take effect July 1, 2010.

*** Sec. 13.** Except as provided in sec. 12 of this Act, this Act takes effect July 1, 2008.

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MEMORANDUM

DATE: **January 25, 2008**
TO: **Senator Bettye Davis**
FROM: **Thomas S. Obermeyer**
RE: **SB 245** – " An Act establishing the Alaska Health Care Commission and the Alaska Health Care Information Office; relating to health care planning and information; repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date." –also known as the "Health care Transparency Act – or Initiative"

Summary

I. This bill attempts to combine three substantive areas of health care into one bill:

1) Creation of a statewide health care plan
2) Establish a 10-member Alaska Health Care Commission with Executive Director to be partially exempt
3) Repeal Certificate of Need program (CON)
   A. Dismiss pending administrative appeals and court actions regarding CON. – allow transition to 7/1/2010.
   B. Allow continuation of "certain health care facilities," defined as critical care hospitals, nursing homes, and residential psychiatric treatment centers

II. Sections 1, 2, and 5 of SB 245 are to take effect immediately, *i.e.*, July 1, 2008.

III. Sections, 3,4, and 6-10 to repeal CON take effect immediately, with exceptions for pending appeals and litigation extended to 7/1/2010, and continuation of "certain health care facilities" defined per above to include critical care hospitals, nursing homes and psychiatric treatment facilities.

Sectional Analysis

The Sectional Analysis of SB245 HB337 by the Department of Health and Social Services is to be changed per the amendments as follows:

Section 1. No change to plan to create Alaska Health Care Commission

(section to take effect July 1, 2008)

Section 2. No change to first part regarding policy, strategy and new Alaska Health Care Information Office.
Major change in last section, AS 18.09.110, regarding department information related to health care facilities, pharmacies, drugs, etc. This section is completely rewritten, much more detailed, and demanding.

Note that amendment eliminates need for update of Internet website (which could save $800,000 in fiscal note #1 out of $1,205,600. Elimination of website does not make sense as it is integral to program. Perhaps it is included in another part of the bill which I have not discovered.
Section to take effect July 1, 2008)

Sections 3 & 4. No changes, except on page 8, additions to definitions of "health care facility" to mean: A) a facility licensed under AS 47.32; B) an independent diagnostic testing facility providing services in the state; and per amendment, C) provider of home and community-based waiver service certified by state; and D) provider of personal care services that is certified under regulations of the department.

Section 5. No change in executive director classified as partially exempt.
(section to take effect July 1, 2008)

Section 6. No change in repeal of CON program.

Section 7. No change in annulling regulations governing the Certificate of Need Program, except for typo change.

Section 8. Allows until July 1, 2010 for Commission of HSS and Dept. of Law to dismiss pending administrative appeals and court actions concerning CON.

Section 9. Completely replace with "Transition: Continuation of certificate of need requirements for 'certain health care facilities'" defined above to include critical care hospitals, nursing homes and psychiatric treatment facilities.

Section 10. Renumbered sections to take effect immediately: 3, 4, and 6-10.

Section 11. Sections 1,2, an5 to take effect July 1, 2008.

Fiscal Notes

Fiscal Note 1: FY 2009 requires appropriation of $1,205,600 and about $200,000 higher for FY 2010-2013. If Internet website eliminated per amendment,, i.e., line 17, page 7 (C), savings could be $800,000 and part of 4 personnel.
Repeal of CON results in savings of $3 million per year in payments for avoided capital costs (50% federa/50%GF/M). This represents 1.2% of total project costs for these facilities.
Page 2 details summary of expenditures and savings.

Fiscal Note 2:

Costs $800,100 for FY 2009 and similar through 2013 to create and man Alaska Health Care Information Office and related website. Costs could be lower and fewer than the 2 personnel if website eliminated, but this may not be necessary or intended as I read the bill.
Detail summary of expenditures and savings, fiscal note 2, page 2 is identical to fiscal note 1, page 2.

Fiscal Note 3.

Eliminates CON program; saves $304,600 and eliminates 2 positions.
Detail summary of expenditures and savings, fiscal note 3, page 2 is identical to fiscal notes 1 and 2, page 2.

Fiscal Note 4.

Establishes cost of Alaska Health Care Commission at $710,100, including 2 FT positions.

Detail summary of expenditures and savings, fiscal note 4, page 3 is identical to fiscal notes 1,2 and 3, page 2.

Sarah Palin
Governor
P.O. Box 110001
Juneau, AK 99811-0001
www.gov.state.ak.us

STATE OF ALASKA
OFFICE OF THE GOVERNOR

Sharon Leighow
Deputy Press
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FOR IMMEDIATE RELEASE **No. 08-006**

Governor Palin Introduces the Health Care Transparency Act

January 19, 2008, Juneau, Alaska - Governor Sarah Palin today introduced the Alaska Health Care Transparency Act which will provide more effective tools to help Alaskans access affordable health care, and to ensure our health care system is responsive to changing demographics and market conditions.

The Act includes some recommendations from the Health Care Strategies Planning Council and the Health and Social Services Certificate of Need Negotiated Rule Making Committee.

"I thank the members of these two committees," Governor Palin said. "They worked diligently to evaluate the broad spectrum of the health care system in our state. After reviewing their work, I am establishing the Alaska Health Care Commission to further health care planning from a statewide perspective, by building on the work they have done."

The bill would establish an Alaska health care information office to give consumers factual information on quality, cost and other important matters to help them make better-informed decisions about health care in the state. Recognizing that health care must be market-and business-driven, rather than restricted by government, Governor Palin is proposing a repeal of the Certificate of Need program (CON).

CON is a regulatory process that requires certain health care providers to obtain state approval before offering certain new or expanded services.

Health and Social Services Commissioner Karleen Jackson concluded that the CON program does not benefit the citizens of Alaska, given the litigious environment surrounding it.

The reports from the two committees are available online at:
http://www.hss.state.ak.us/commissioner/legislature/

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DHSS Contacts: Sherry Hill (907) 465-1618, cell (907) 321-2838
Wilda Laughlin (907) 465-1613, cell (907) 723-3802

SENATE BILL NO. 245

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY THE SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

Introduced: 1/19/08
Referred: Health, Education and Social Services, Finance

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about

health issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including

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municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

* **Sec. 2.** AS 18 is amended by adding a new chapter to read:

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(1) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state; and

(2) to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

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(1) the state officer assigned the duties of medical director for the department;

(2) one member representing the Department of Administration, appointed by the commissioner of administration;

(3) one member representing the Department of Commerce, Community, and Economic Development, appointed by the commissioner of commerce, community, and economic development;

(4) one member representing the Department of Labor and Workforce Development, appointed by the commissioner of labor and workforce development;

(5) three public members, appointed by the governor; one of the members appointed under this paragraph must be a small business owner in the state;

(6) one ex officio nonvoting member from the house of representatives, appointed by the speaker of the house, and one ex officio nonvoting member from the senate, appointed by the president of the senate;

(7) an ex officio nonvoting member representing the office of the

governor.

(b) The department's representative appointed under (a)(1) of this section shall serve as chair of the commission.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(a)(5) serve for staggered terms of three years.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) The governor may remove a public member of the commission from office only for cause.

Sec. 18.09.040. Executive director. The commission shall employ an executive director, who may not be a member of the commission. The executive director shall serve at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

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Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing its proceedings, and other activities, including provisions concerning a quorum to transact commission business and other aspects of procedure, frequency and location of meetings, and establishment, functions, and membership of committees.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for encouraging

(A) personal responsibility in prevention and healthy living for all residents of the state;

(B) reductions in health care costs for all residents of the state

to below the national average;

(C) access in communities to safe water and wastewater systems;

(D) the development of a sustainable health care workforce in the state;

(E) quality health care being accessible for all residents of the state; and

(F) increasing the number of residents of the state who are covered by insurance for health care services.

(b) The commission shall review and approve health care information for placement on the department's database developed under AS 18.09.110.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities.

Sec. 18.09.080. Compensation, per diem, and expenses. A public member appointed to the commission under AS 18.09.020(a)(5) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

Article 2. Alaska Health Care Information Office.

Sec. 18.09.100. Office. The Alaska health care information office is established in the department. The purpose of the office is to improve access by residents of the state to consistently updated

(1) facility information to aid consumers of health care services from health care facilities in the state; and

(2) information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110. Dissemination of information. (a) The department shall establish and maintain an information database on the Internet for all health care facilities in the state in order to provide objective, unbiased, and factually based information on health care facilities in the state. The department may require those health care facilities to provide information in a standard form or format to the

department for placement on the database. Before information is placed on the database, the commission shall review the information for accuracy.

(b) The database developed under (a) of this section must include the following:

(1) a geographically indexed list of all health care facilities in the state by region;

(2) information on costs to the consumer for health care services provided by health care facilities;

(3) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility;

(4) the types and scope of health care services provided by each health care facility;

(5) types of insurance and payment accepted by each health care facility for health care services.

(c) The department shall develop and consistently update an Internet website to provide residents of the state timely and accurate information regarding prevention and healthy living.

(d) The department shall post and make available information related to the commission, including the commission's annual reports under AS 18.09.070(c).

Sec. 18.09.120. Mandatory reporting. (a) A health care facility shall provide to the department the following information related to the facility's health care services for placement on the database developed under AS 18.09.110:

(1) information on costs to the consumer for health care services;

(2) types of insurance and payment accepted by the health care facility for health care services;

(3) each location where the health care facility operates, and hours of operation;

(4) the types and scope of health care services offered at the health care facility;

(5) the Internet address of any website of the health care facility to provide factual information to aid the consumer;

(6) any other readily accessible information that the department determines would be helpful to the consumer to make informed decisions about the health care facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of any failure to report under (a) of this section and give the health care facility an opportunity to contest or cure any failures. If the health care facility does not promptly cure any failure, the department shall post the notice of failure on the database developed under AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide information to the commission regarding an adverse action taken against a health care facility in the state, or against a licensed professional practicing in a health care facility in the state, for placement on the database developed under AS 18.09.110; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "cost to consumers" means actual prices paid by consumers for health care services;

(3) "department" means the Department of Health and Social Services;

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing services in the state;

* **Sec. 3.** AS 18.26.220 is amended to read:

Sec. 18.26.220. Facility compliance with health and safety laws and licensing requirements. A medical facility constructed, acquired, improved, financed, or otherwise under the provisions of this chapter and all actions of the authority are subject to [AS 18.07,] AS 47.32[,] and any other present or future state licensing requirements for the facilities or services provided under this chapter. [A MEDICAL FACILITY ISSUED A CERTIFICATE OF NEED UNDER SEC. 4, CH. 275, SLA 1976, BY VIRTUE OF BEING IN EXISTENCE OR UNDER CONSTRUCTION BEFORE JULY 1, 1976, MUST FULLY MEET THE REQUIREMENTS OF AS 18.07 IN ORDER TO BE ELIGIBLE FOR FUNDING UNDER THIS CHAPTER.]

* **Sec. 4.** AS 21.86.030(c) is amended to read:

(c) Nothing in this section relieves a health maintenance organization that wishes to exercise the power described in (a)(1) of this section from the requirements of

(1) [AS 18.07, regarding obtaining a certificate of need;

(2)] AS 47.32, regarding regulation of hospitals; and

(2) [(3)] other statutes applicable to hospitals or other health care facilities.

* **Sec. 5.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

* **Sec. 6.** AS 18.07.021, 18.07.031, 18.07.035, 18.07.041, 18.07.043, 18.07.045, 18.07.051, 18.07.061, 18.07.071, 18.07.081, 18.07.091, 18.07.101, 18.07.111; and AS 47.80.140(b) are repealed.

* **Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to read:

ANNULMENT, AMENDMENT, AND REPEAL OF REGULATIONS. (a) The following regulations are annulled:

(1) 7 AAC 07.010, 7 AAC 07.012, 7 AAC 07.015, 7 AAC 07.025, 7 AAC 07.031, 7 AAC 07.032, 7 AAC 07.033, 7 AAC 07.035, 7 AAC 07.040, 7 AAC 07.042, 7 AAC 07.050, 7 AAC 07.052, 7 AAC 07.060, 7 AAC 07.067, 7 AAC 07.070, 7 AAC 07.072, 7 AAC 07.079, 7 AAC 07.080, 7 AAC 07.092, 7 AAC 07.095, 7 AAC 07.105, 7 AAC 07.107, and 7 AAC 07.900;

(2) 7 AAC 09.030(b)(3) and 7 AAC 09.170(5);

(3) 7 AAC 43.689(g)(4)(B);

(4) 15 AAC 118.020(c)(3) and (d)(1).

(b) The commissioner of health and social services shall immediately proceed under

AS 44.62 to amend or repeal the following regulations in accordance with the provisions of this Act:

(1) 7 AAC 09.020;

(2) 7 AAC 43.679, 7 AAC 43.685, 7 AAC 43.686, and 7 AAC 43.709.

*** Sec. 8.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: PENDING APPLICATIONS, ADMINISTRATIVE APPEALS, AND COURT ACTIONS FOR THE CERTIFICATE OF NEED PROGRAM. (a) The commissioner of health and social services through the Department of Law shall immediately take steps to seek dismissal of pending administrative appeals and court actions concerning the issuance of certificates of need under AS 18.07 or implementation of AS 18.07.

(b) The Department of Health and Social Services shall immediately close all pending application files under AS 18.07. The Department of Health and Social Services shall send written notification to the applicant of the action taken under this subsection.

*** Sec. 9.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before July 1, 2008.

*** Sec. 10.** Sections 3, 4, 6 – 8, and 9 of this Act take effect immediately under AS 01.10.070(c).

*** Sec. 11.** Except as provided in sec. 10 of this Act, this Act takes effect July 1, 2008.

25G-2
1/24/2008
(1:42 pm)

AMENDMENT

OFFERED IN THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE BY _____

TO: SB 245

Page 6, lines 5 - 16:

Delete all material and insert:

"(1) the list of preferred drugs approved by the department for reimbursement by the department;

(2) a complete list, organized by region and address, of

(A) health facilities located in the state;

(B) licensed pharmacists and pharmacies located in the state;

(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state;

(G) public assistance offices of the department;

(3) a list of the 100 most commonly prescribed medications in the state and the source and price, updated monthly, of the medications;

(4) a list of the 100 most commonly conducted medical procedures in the state, organized by the cash and negotiated price of the procedure at available providers and insurers, updated annually; the list must include medical procedures covered by workers' compensation under AS 23.30;

(5) available hospital ratings, including the rates of hospital-acquired infections and mortality occurring at each hospital located in the state;

(6) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, and that includes the location of available sites that provide care and treatment;

(7) a list of procedures approved by state agencies for emergency response and treatment;

(8) disease management support information;

(9) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

(B) links to Internet websites for purchasing insurance policies; and

(C) an explanation of mandatory and optional insurance coverage;

(10) a list of primary care clinics that cater to uninsured and self-pay patients; and

(11) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility.

(c) The department may contract with a private entity to provide services and information required under (b) of this section."

Page 6, line 17:

Delete "(c)"

Insert "(d)"

Page 6, line 20:

Delete "(d)"

Insert "(e)"

Page 8, line 6:

Delete "."

Insert ";"

Page 8, following line 6:

Insert

"(C) a provider of a home and community-based waiver service that is certified under regulations of the department;

(D) a provider of personal care services that is certified under regulations of the department."

Page 8, line 23:

Delete "AS 47.32."

Insert "AS 47.32,"

Page 9, line 28:

Delete "7 AAC 09.030(b)(3)"

Insert "7 AAC 09.030(3)"

Page 10, following line 15:

Insert a new bill section to read:

"* **Sec. 9.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: CONTINUATION OF CERTIFICATE OF NEED REQUIREMENTS FOR CERTAIN HEALTH CARE FACILITIES. (a) Notwithstanding sec. 6 of this Act, the provisions of former AS 18.07.021, 18.07.031, 18.07.035, 18.07.041, 18.07.043, 18.07.045, 18.07.051, 18.07.061, 18.07.071, 18.07.081, 18.07.091, 18.07.101, 18.07.111, and AS 47.80.140(b) continue in effect as they read on June 30, 2008 for certain health care facilities as defined in (e) of this section.

(b) Notwithstanding sec. 7(a) of this Act, the provisions of the following regulations continue in effect as they read on June 30, 2008 for certain health care facilities defined in (e) of

this section:

(1) 7 AAC 07.010, 7 AAC 07.012, 7 AAC 07.015, 7 AAC 07.025, 7 AAC 07.031, 7 AAC 07.032, 7 AAC 07.033, 7 AAC 07.035, 7 AAC 07.040, 7 AAC 07.042, 7 AAC 07.050, 7 AAC 07.052, 7 AAC 07.060, 7 AAC 07.067, 7 AAC 07.070, 7 AAC 07.072, 7 AAC 07.079, 7 AAC 07.080, 7 AAC 07.092, 7 AAC 07.095, 7 AAC 07.105, 7 AAC 07.107, and 7 AAC 07.900;

(2) 7 AAC 09.030(3) and 7 AAC 09.170(5);

(3) 7 AAC 43.689(g)(4)(B);

(4) 15 AAC 118.020(c)(3) and (d)(1).

(c) Notwithstanding sec. 8 of this Act, the commissioner of health and social services may not immediately take the actions required by sec. 8 of this Act for the certain health care facilities until July 1, 2010.

(d) The provisions of this section apply only until June 30, 2010.

(e) In this section,

(1) "certain health care facilities" means

(A) critical access hospitals;

(B) nursing homes;

(C) residential psychiatric treatment centers;

(2) "critical access hospital" means a facility that is a hospital licensed in this state that satisfies the criteria set out at 42 U.S.C. 1395i-4(c)(2)(B) and meets the conditions of participation set out in 42 C.F.R. 485.601 - 485.647;

(3) "nursing home" means a nursing facility as defined in 42 U.S.C. 1396r(a);

(4) "residential psychiatric treatment center" means a secure or semi-secure psychiatric facility or inpatient program in a psychiatric facility that is licensed by the Department of Health and Social Services and that provides therapeutically appropriate and medically necessary diagnostic, evaluation, and treatment services

(A) 24 hours a day for children with severe emotional or behavioral disorders;

(B) under the direction of a physician; and

(C) under a professionally developed and supervised individual plan of care that is designed to achieve the recipient's discharge from inpatient status at the

earliest possible time, and that is intensively and collaboratively delivered by an interdisciplinary team involving medical, mental health, educational, and social service components."

Renumber the following bill sections accordingly.

Page 10, line 22:

Delete "Sections 3, 4, 6 - 8, and 9"

Insert "Sections 3, 4, and 6 - 10"

Page 10, line 24:

Delete "sec. 10"

Insert "sec. 11"

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 245
(S) Publish Date: 1/19/08

ID(File name): 0050-DHSS-MS-1-18-08
Title: HEALTH CARE TRANSPARENCY ACT
Sponsor: RULES COMMITTEE
Requester:

Dept. Affected: Health & Social Services
RDU: Health Care Services
Component: Medicaid Services
Component No: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	•		•	•	•	•	•
Miscellaneous							
TOTAL OPERATING	•	**0.0**	•	•	•	•	•
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	•		•	•	•	•	•
1003 GF Match	•		•	•	•	•	•
1004 GF							
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	•	**0.0**	•	•	•	•	•

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

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

This bill eliminates the Certificate of Need program. This fiscal note is indeterminate. Eliminating the CON program would likely increase costs to Medicaid, however the costs are unknown at this time.

This fiscal note is based on projects denied, withdrawn, or reduced as the result of the CON program which is estimated to have saved the Alaska Medicaid program approx. $3 million per year in payments for avoided capital costs (50% federal/50% GF/M). This represents 1.2% of the total project costs for these facilities.

Prepared by: William Streur, Deputy Commissioner — Phone: 465-5830
Division: Health Care Services — Date/Time: 01/16/2008
Approved by: Karleen Jackson, Commissioner — Date: 01/18/2008
Agency: Department of Health and Social Services

FISCAL NOTE
FN # 1

STATE OF ALASKA
2008 LEGISLATIVE SESSION

BILL NO. SB 245

ANALYSIS CONTINUATION

HEALTH CARE TRANSPARENCY INITIATIVE

Fiscal Note Summary by Component
Department of Health & Social Services

Dollars in thousands		Appropriation Required FY2009	Information FY2009	FY2010	FY2011	FY2012	FY2013
Total All Expenditures by Fund Source	Total	$1,205.6	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$1,420.7	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Health Care Services Medicaid Services Indeterminate additional cost to Medicaid if CON eliminated	Total	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Departmental Support Svcs Health Planning & Infrastructure Savings if CON program is eliminated. Eliminates revenues from CON application fees	Total	($304.6)	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	($89.5)	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Commissioner's Office AK Health Care Information Office Establishes new office in DHSS and Internet site to provide consumers information about all health care facilities in the state	Total	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Boards & Commissions AK Health Care Commission Establish new commission in DHSS to develop statewide plan addressing the quality, accessibility and availability of health care in Alaska	Total	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Total All Positions	Full time	4	0	4	4	4	4
Health Care Services Medicaid Services	Full time	0	0	0	0	0	0
Departmental Support Svcs Health Planning & Infrastructure	Full time	-2	0	-2	2	-2	-2
Commissioner's Office AK Health Care Information Office	Full time	4	0	4	4	4	4
Boards & Commissions AK Health Care Commission	Full time	2	0	2	2	2	2

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: SB 245
(S) Publish Date: 1/19/08

ID(File name): 0050-DHSS-AHCIO-1-18-08
Dept Affected: Health & Social Services
Title: HEALTH CARE TRANSPARENCY ACT
RDU: Commissioner's Office
Component: AK Health Care Information Office
Sponsor: RULES COMMITTEE
Requester:
Component No: 2899

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services	494.9		494.9	494.9	494.9	494.9	494.9
Travel	18.0		18.0	18.0	18.0	18.0	18.0
Contractual	250.0		235.0	235.0	235.0	235.0	235.0
Supplies	22.2		10.0	10.0	10.0	10.0	10.0
Equipment	15.0		10.0	10.0	10.0	10.0	10.0
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**800.1**	**0.0**	**767.9**	**767.9**	**767.9**	**767.9**	**767.9**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	800.1		767.9	767.9	767.9	767.9	767.9
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	**800.1**	**0.0**	**767.9**	**767.9**	**767.9**	**767.9**	**767.9**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time	4		4	4	4	4	4
Part-time							
Temporary							

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

The bill creates the Alaska Health Care Information Office and a related Internet site to provide consumers consistently updated information about all health care facilities in the state.

71000 Personal Services Two information technology positions are being requested to design, develop, implement, and support the dissemination of information on the internet for all health care facilities in the state to provide objective, unbiased, and factually based information on those facilities. In addition, an interactive website will be created to assist the public in obtaining timely and accurate information about personal responsibility in preventing chronic health conditions and promoting healthy living. Two planner positions will be needed to assist in research and data collection for the Commission.

Prepared by: Jay C. Butler, MD — Phone: 269-8045
Division: Chief Medical Officer — Date/Time: 01/17/2008
Approved by: Karleen Jackson, Commissioner — Date: 01/18/2008
Agency: Department of Health and Social Services

STATE OF ALASKA
2008 LEGISLATIVE SESSION

BILL NO: SB 245

ANALYSIS CONTINUATION

Funding is needed to support two existing positions—Public Information Officer and Publications Technician. These positions will coordinate internal and external communications for the Alaska Health Care Information Office.

72000 Travel
Travel and per diem for professional staff.

73000 Contractual
Professional services contracts will be needed to facilitate and supplement formative research methods to develop and messages to promote healthy behaviors. Core Service RSAs will be required to provide lease space, telecommunications, mainframe connectivity, postage, etc.

74000 Supplies
In addition to day-to-day office supplies; FY09 includes one-time-only start-up costs such as computers, office furniture, reconfiguring leased space, wiring needs for connectivity, printers, fax, and photocopier.

75000 Equipment
FY09 includes a one-time-only purchase of a server; subsequent fiscal years provide for technology upgrades and maintenance.

A summary of the overall impact of this legislation follows on the next page.

FISCAL NOTE
FN # 2

STATE OF ALASKA
2008 LEGISLATIVE SESSION

BILL NO. SB 245

ANALYSIS CONTINUATION

HEALTH CARE TRANSPARENCY INITIATIVE

Fiscal Note Summary by Component
Department of Health & Social Services

Dollars in thousands		Appropriation Required FY2009	Information FY2009	FY2010	FY2011	FY2012	FY2013
Total All Expenditures by Fund Source	Total	$1,205.6	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$1,420.7	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Health Care Services Medicaid Services Indeterminate additional cost to Medicaid if CON eliminated	Total	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Departmental Support Svcs Health Planning & Infrastructure Savings if CON program is eliminated. Eliminates revenues from CON application fees	Total	($304.6)	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	($89.5)	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Commissioner's Office AK Health Care Information Office Establishes new office in DHSS and Internet site to provide consumers information about all health care facilities in the state	Total	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Boards & Commissions AK Health Care Commission Establish new commission in DHSS to develop statewide plan addressing the quality, accessibility and availability of health care in Alaska	Total	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Total All Positions	Full time	4	0	4	4	4	4
Health Care Services Medicaid Services	Full time	0	0	0	0	0	0
Departmental Support Svcs Health Planning & Infrastructure	Full time	2	0	2	2	2	2
Commissioner's Office AK Health Care Information Office	Full time	4	0	4	4	4	4
Boards & Commissions AK Health Care Commission	Full time	2	0	2	2	2	2

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 3
Bill Version: SB 245
(S) Publish Date: 1/19/08

ID(File name): 0050-DHSS-HPI-1-18-08
Dept Affected: Health & Social Services
Title: HEALTH CARE TRANSPARENCY ACT
RDU: Departmental Support Services
Component: Health Planning & Infrastucture

Sponsor: RULES COMMITTEE
Requester:
Component No: 2765

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services	(190.1)						
Travel	(21.6)						
Contractual	(90.9)						
Supplies	(2.0)						
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**(304.6)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	(44.8)						
1003 GF Match	(44.8)						
1004 GF	(89.5)						
1037 GF/Mental Health							
1156 Receipt Support Svcs (RSS)	(125.5)						
Other(Specify Type-do not abbreviate)							
TOTAL	**(304.6)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2008) cost: _____

POSITIONS

Full-time	-2						
Part-time							
Temporary							

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

This bill eliminates the Certificate of Need program. These sections take effect immediately so FY09 is for a full year. This fiscal note estimates the savings in personal services and other administrative costs from elimination of the Certificate of Need office in Health Planning & Infrastructure. Expenditures are based on FY07 actuals and include legal services for CON hearings & appeals. Two positions would be eliminated. Revenue from CON application fees would be eliminated (all of Receipt Support Services). Revenue estimates for RSS are based on FY08 Managment Plan and the remainder is pro-rated at 50% Medicaid reimbursable 50% non-reimbursable. The Medicaid costs are 50% federal 50% GF Match.

A summary analysis of the impacts of this legislation follows on next page.

Prepared by: Dr. Jay Butler, Chief Medical Officer — Phone: 269-7800
Division: Commissioner's Office — Date/Time: 01/16/2008
Approved by: Karleen Jackson, Commissioner — Date: 01/18/2008
Agency: Department of Health and Social Services

FISCAL NOTE
FN # 3

STATE OF ALASKA
2008 LEGISLATIVE SESSION

BILL NO. SB 245

ANALYSIS CONTINUATION

HEALTH CARE TRANSPARENCY INITIATIVE

Fiscal Note Summary by Component
Department of Health & Social Services

Dollars in thousands		Appropriation Required	Information				
		FY2009	**FY2009**	**FY2010**	**FY2011**	**FY2012**	**FY2013**
Total All Expenditures by Fund Source	Total	$1,205.6	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$1,420.7	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Health Care Services Medicaid Services Indeterminate additional cost to Medicaid if CON eliminated	Total	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Departmental Support Svcs Health Planning & Infrastructure Savings if CON program is eliminated. Eliminates revenues from CON application fees	Total	($304.6)	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	($89.5)	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Commissioner's Office AK Health Care Information Office Establishes new office in DHSS and Internet site to provide consumers information about all health care facilities in the state	Total	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Boards & Commissions AK Health Care Commission Establish new commission in DHSS to develop statewide plan addressing the quality, accessibility and availability of health care in Alaska	Total	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Total All Positions	Full time	4	0	4	4	4	4
Health Care Services Medicaid Services	Full time	0	0	0	0	0	0
Departmental Support Svcs Health Planning & Infrastructure	Full time	2	0	-2	2	-2	-2
Commissioner's Office AK Health Care Information Office	Full time	4	0	4	4	4	4
Boards & Commissions AK Health Care Commission	Full time	2	0	2	2	2	2

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 4
Bill Version: SB 245
(S) Publish Date: 1/19/08

ID(File name) 0050-DHSS-AHCC-1-18-08
Dept Affected: Health & Social Services
Title: HEALTH CARE TRANSPARENCY ACT
RDU: Boards & Commissions
Component: AK Health Care Commission
Sponsor: RULES COMMITTEE
Requester:
Component No: 2900

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services	173.1		173.1	173.1	173.1	173.1	173.1
Travel	200.0		200.0	200.0	200.0	200.0	200.0
Contractual	250.0		250.0	250.0	250.0	250.0	250.0
Supplies	72.0		10.0	10.0	10.0	10.0	10.0
Equipment	15.0		10.0	10.0	10.0	10.0	10.0
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**710.1**	**0.0**	**643.1**	**643.1**	**643.1**	**643.1**	**643.1**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	710.1		643.1	643.1	643.1	643.1	643.1
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	**710.1**	**0.0**	**643.1**	**643.1**	**643.1**	**643.1**	**643.1**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time	2		2	2	2	2	2
Part-time							
Temporary							

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

This bill permanently establishes the Alaska Health Care Commission in DHSS to develop a statewide plan addressing the quality, accessibility and availability of health care in Alaska.

71000 Personal Services: Two new positions are needed to support the Commission. Costs are estimated for an Executive Director and administrative support position.

72000 Travel: Travel and per diem for Commission staff; and, travel and per diem for ten Commission members to conduct public meetings around the state.

Prepared by: Jay C. Butler, MD
Phone: 269-8045
Division: Chief Medical Officer
Date/Time: 01/17/2008
Approved by: Karleen Jackson, Commissioner
Date: 01/18/2008
Agency: Department of Health and Social Services

STATE OF ALASKA **BILL NO: SB 245**
2008 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

73000 Contractual
Professional services contracts will be needed to supplement staff research and core service RSAs will be required to provide lease space, telecommunications, mainframe connectivity, postage, etc.

74000 Supplies
In addition to day-to-day office supplies; FY09 includes one-time-only start-up costs such as computers, office furniture, reconfiguring leased space, wiring needs for connectivity, printers, fax, and photocopier.

75000 Equipment
FY09 includes a one-time-only purchase of a server; subsequent fiscal years provide for technology upgrades and maintenance

A summary of the overall impact of this legislation follows on next page.

FISCAL NOTE
FN # 4

STATE OF ALASKA
2008 LEGISLATIVE SESSION

BILL NO. SB 245

ANALYSIS CONTINUATION

HEALTH CARE TRANSPARENCY INITIATIVE

Fiscal Note Summary by Component
Department of Health & Social Services

Dollars in thousands		Appropriation Required FY2009	Information FY2009	FY2010	FY2011	FY2012	FY2013
Total All Expenditures by Fund Source	Total	$1,205.6	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$1,420.7	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Health Care Services Medicaid Services Indeterminate additional cost to Medicaid if CON eliminated	Total	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Departmental Support Svcs Health Planning & Infrastructure Savings if CON program is eliminated Eliminates revenues from CON application fees	Total	($304.6)	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	($89.5)	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Commissioner's Office AK Health Care Information Office Establishes new office in DHSS and Internet site to provide consumers information about all health care facilities in the state	Total	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Boards & Commissions AK Health Care Commission Establish new commission in DHSS to develop statewide plan addressing the quality, accessibility and availability of health care in Alaska	Total	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Total All Positions	Full time	4	0	4	4	4	4
Health Care Services Medicaid Services	Full time	0	0	0	0	0	0
Departmental Support Svcs Health Planning & Infrastructure	Full time	2	0	2	2	2	2
Commissioner's Office AK Health Care Information Office	Full time	4	0	4	4	4	4
Boards & Commissions AK Health Care Commission	Full time	2	0	2	2	2	2

STATE OF ALASKA

SARAH PALIN, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

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

Sectional Analysis
SB 245/HB 337 Health Care Transparency Act

Section 1. AS 18.05.010(b)

Requires the Department of Health and Social Services to implement a statewide health plan under AS 18.09, which is a new chapter creating the Alaska Health Care Commission.

Sec. 2. AS 18.09

Establishes a 10-member Alaska Health Care Commission within the Department of Health and Social Services. The purpose of the Commission is to develop a statewide plan to address the quality, accessibility and availability of health care for all citizens of the state; and to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Section 2 also specifies that the plan contain a health care policy and a strategy for encouraging: personal responsibility and reductions in health care costs; access to safe water and wastewater systems; development of a sustainable health care workforce; accessible quality health care; and an increase in the number of residents who are covered by insurance.

Establishes an Alaska Health Care Information Office to provide consistently updated health care facility information to aid consumers of health care serves, and information to encourage personal responsibility in prevention and healthy living.

Finally, the section requires health care facilities to provide the department information related to the facility's health care services for placement on the database developed under AS 18.09.110.

Sec. 3. AS 18.26.220 and Sec. 4 AS 21.86.030(c)

Technical, conforming edits to reflect the repeal of the CON program (see Sec. 6).

Sec. 5 AS 39.25.120(c)(7)

Specifies that the principal executive officer of the Alaska Health Care Commission is classified as partially exempt.

Sec. 6

Repeals 18.07, the Certificate of Need Program; and 47.80.140(b), which requires a certificate of need as a prerequisite for licensing a residential facility after July 1, 1978.

Sec. 7.

Annuls regulations governing the Certificate of Need Program.

Revised: 1/24/2008

Sec. 8

Directs the commissioner of the Department of Health and Social Services and Department of Law to immediately take steps to seek dismissal of pending administrative appeals and court actions concerning the issuance of certificates of need under AS 18.07. Requires the Department of Health and Social Services to immediately close all pending application files under AS 18.07.

Sec. 9

Allows the Department of Health and Social Services to adopt regulations necessary to implement changes made by this Act.

Sec. 10

Sets an immediate effective date for:

Section 3 and 4, technical amendments to reflect repeal of certificate of need program;

Section 6, repealing 18.07, certificate of need program;

Section 7, annulling regulations governing the certificate of need program;

Section 8, dismissing pending administrative appeals and court actions; and closing all pending application files under the certificate of need program;

Section 9, allowing the department to adopt regulations to implement changes made in the act.

Sec. 11

Sets an effective date of July 1, 2008 for:

Section 1, requiring the department to implement a statewide health plan;

Section 2, establishing the Alaska Health Care Commission and the Alaska Health Care Information Office;

Section 5, specifying the executive officer of the Health Care Commission as partially exempt.

Thomas Obermeyer

From: Hill, Sherry (HSS) [sherry.hill@alaska.gov]
Sent: Friday, February 01, 2008 11:44 AM
To: Thomas Obermeyer
Subject: FW: Senate H.E.S.S. Schedule Fenruary 4 - 8
Importance: High
Attachments: HB337 CS (E) 013108.pdf; Changes in the CS for House Bill 337.doc

as discussed

Note my new e-mail address! Sherry.Hill@alaska.gov

Sherry Hill, MS, PR
Assistant Commissioner for Public Affairs
Alaska Department of Health and Social Services
PO Box 110601
Juneau, AK 99811-0601
907-465-1618 cell 907-321-2838

From: Hill, Sherry (HSS)
Sent: Friday, February 01, 2008 7:26 AM
To: Burrell, Don (LAA)
Cc: Rooney, Rebecca (LAA)
Subject: RE: Senate H.E.S.S. Schedule Fenruary 4 - 8
Importance: High

thanks Don!
Here is the CS that House HES adopted. There are a couple of areas we still need to tweak but this would give Senate HES a working document. I am also attaching a summary matrix which will help to decipher what was changed by whom (Becky this is for you too!).
What we still are working on:
Changed:

- the information that we will collect for the Health Info Office web site – leaves us to determine parameters in regulation (page 6 lines 14-17, paragraph (2) is still causing a lot of discussion so there will likely be some changes to this)
- composition of the board
- leaves CON intact for RPTC, Nursing Homes, and Critical Access Hospitals but eliminates the rest. (Sec. 2.3 page 3 lines 1-10)

One thing that could be a problem – WE THINK that the third item will NOT protect Critical Access Hospitals in small communities because it won't prevent a diagnostic imaging center, or ambulatory surgery center from building in those communities – so House HES will be discussing.

Note my new e-mail address! Sherry.Hill@alaska.gov

Sherry Hill, MS, PR
Assistant Commissioner for Public Affairs
Alaska Department of Health and Social Services
PO Box 110601
Juneau, AK 99811-0601
907-465-1618 cell 907-321-2838

From: Don Burrell [mailto:Don_Burrell@legis.state.ak.us]
Sent: Thursday, January 31, 2008 5:16 PM
To: Hill, Sherry (HSS); Bryan Butcher; Fulton, Trevor M (LAA); Wielechowski, Bill (LAA); Ascott, George (LAA); Pustay, Katherine (LAA); Ledoux, Gabrielle R (LAA); Hancock, Suzanne J (LAA)
Subject: Senate H.E.S.S. Schedule February 4 - 8

Good evening everyone!

Senator Davis wanted everyone to be aware that one of your bills is on the Senate H E S.S. schedule next week Attached is that schedule.
Please contact our office if you have any additional information that needs to be added to committee members packets or if you have any questions.

The bill will be heard in the order listed on the schedule.

Please let me know if you need any additional information and we will see you next week.

Don Burrell Jr.
Legislative Aide
Office of Senator Bettye Davis
State Capitol Room 30
Juneau, Alaska 99801
907-465-3822 P
907-465-3756 F
don_burrell@legis.state.ak.us

25-GH2050\E
Mischel
1/30/08

CS FOR HOUSE BILL NO. 337(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"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."

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

* Section 1. AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, AS 18.09, and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to

develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking; program evaluation; and monitoring, testing, and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers within the public health system to achieve the mission of public health.

New Text Underlined [DELETED TEXT BRACKETED]

* **Sec. 2.** AS 18.07.111(8) is repealed and reenacted to read:

(8) "health care facility" means a residential psychiatric treatment center and a private, municipal, state, or federal hospital that has been designated by the department as a critical access hospital;

* **Sec. 3.** AS 18.07.111 is amended by adding new paragraphs to read:

(11) "critical access hospital" means a facility that is a hospital licensed in the state that satisfies the criteria set out in 42 U.S.C. 1395i-4(c)(2)(B) and meets the conditions of participation set out in 42 C.F.R. 485.601 - 485.647;

(12) "nursing home" means a nursing facility, as defined in 42 U.S.C. 1396r(a).

* **Sec. 4.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care Planning and Information.

Article 1. Alaska Health Care Commission; State Health Plan.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purposes of the commission are

(1) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state; and

(2) to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Sec. 18.09.020. Composition; chair. (a) The commission consists of 12 members as follows:

(1) the state officer assigned the duties of medical director for the department;

(2) one member representing the Department of Administration, appointed by the commissioner of administration;

(3) one member representing the Department of Commerce, Community, and Economic Development, appointed by the commissioner of commerce, community, and economic development;

(4) one member representing the Department of Labor and

[DELETED TEXT BRACKETED AND UNDERLINED; NEW TEXT UNDERLINED]

Workforce Development, appointed by the commissioner of labor and workforce development;

(5) six public members, appointed by the governor; one of the members appointed under this paragraph must be a small business owner in the state;

(6) one member from the house of representatives, appointed by the speaker of the house;

(7) one member from the senate, appointed by the president of the senate.

(b) The department's representative appointed under (a)(1) of this section shall serve as chair of the commission.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(a)(5) serve for staggered terms of three years.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) The governor may remove a public member of the commission from office only for cause.

Sec. 18.09.040. Executive director. The commission shall employ an executive director, who may not be a member of the commission. The executive director shall serve at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of staff of the commission.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing proceedings and other activities, including provisions concerning a quorum to transact business and other aspects of procedure, frequency and location of meetings, and establishment, functions, and membership of committees.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal

law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for

(A) encouraging personal responsibility in prevention and healthy living for all residents of the state;

(B) reducing health care costs for all residents of the state to below the national average;

(C) ensuring access in communities to safe water and wastewater systems;

(D) developing a sustainable health care workforce in the state;

(E) ensuring access to quality health care being accessible for all residents of the state; and

(F) increasing the number of residents of the state who are covered by insurance for health care services.

(b) The commission shall review and approve health care information for placement on the department's database developed under AS 18.09.110.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities.

Sec. 18.09.080. Compensation, per diem, and expenses. A public member appointed to the commission under AS 18.09.020(a)(5) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

Article 2. Alaska Health Care Information Office.

Sec. 18.09.100. Office. The Alaska health care information office is established in the department. The purpose of the office is to improve access by residents of the state to consistently updated

(1) information about health care facilities to aid consumers of health care services or health care facilities in the state; and

[DELETED TEXT] [BRACKETED DELETED TEXT HAS BEEN]

(2) information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110. Dissemination of information. (a) The department shall establish and maintain an information database on the Internet of information about all health care facilities in the state to provide objective, unbiased, and factually based information on health care facilities in the state. The department may require those health care facilities to provide information in a standard form or format to the department for placement in the database. Before information is placed in the database, the commission shall review the information for accuracy.

(b) The database developed under (a) of this section must include the following:

(1) the availability and location of state licensed health care providers and facilities, organized by region;

(2) the facility cost and provider cost of medical procedures in the state, organized by the cash price and negotiated price of each procedure charged by available providers and paid by insurers, updated annually; the cost must include the cost to workers' compensation under AS 23.30;

(3) the prescription medication cost in the state, organized by the cash price and negotiated price of each medication;

(4) available hospital ratings, including the rates of hospital acquired infections and mortality occurring at each hospital located in the state.

(c) The department shall develop and consistently update an Internet website to provide residents of the state timely and accurate information regarding prevention and healthy living.

(d) The department shall post and make available information related to the commission, including the commission's annual reports under AS 18.09.070(c).

Sec. 18.09.120. Mandatory reporting. (a) A health care facility shall provide to the department the following information related to the facility's health care services for placement in the database developed under AS 18.09.110:

(1) information on costs to the consumer for health care services;

(2) types of insurance and payment accepted by the health care

facility for health care services;

(3) each location where the health care facility operates, and the hours of operation;

(4) the types and scope of health care services offered at the health care facility;

(5) the Internet address of any Internet website of the health care facility the purpose of which is to provide factual information to aid the consumer;

(6) any other readily accessible information that the department determines would help the consumer make informed decisions about the health care facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of a failure to report under (a) of this section and give the health care facility an opportunity to contest or cure the failure. If the health care facility does not promptly cure the failure, the department shall post the notice of failure on the database developed under AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide to the commission information for placement in the database developed under AS 18.09.110 regarding an adverse action taken against a health care facility in the state or against a licensed professional practicing in a health care facility in the state; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "costs to the consumer" means the actual price paid by the consumer for health care services;

(3) "department" means the Department of Health and Social Services;

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing services in the state;

(C) an agency providing a home and community based waiver service that is certified under regulations adopted by the department;

(D) an agency providing personal care services that is certified under regulations adopted by the department.

* Sec. 5. AS 39.25.120(e)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architects, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

* Sec. 6. The uncodified law of the State of Alaska is amended by adding a new section to read

TRANSITION: PENDING APPLICATIONS, ADMINISTRATIVE APPEALS, AND COURT ACTIONS FOR THE CERTIFICATE OF NEED PROGRAM. The commissioner of health and social services through the Department of Law shall immediately take steps to seek dismissal of pending administrative appeals and court actions concerning the issuance of certificates of need, as appropriate, under AS 18.07, as amended by secs. 1 and 2 of this Act or implementation of AS 18.07.

* **Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to read

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory changes.

* **Sec. 8.** Section 7 of this Act takes effect immediately under AS 01.10.070(c).

* **Sec. 9.** Except as provided in sec. 8 of this Act, this Act takes effect July 1, 2008.

Changes in the CS for House Bill 337

HB337 original	DHSS amendment	HES changes	HB 337 CS
Creates **Health Care Commission** to review health care policy and develop a plan – 10 members • DHSS Med. Officer (Chair) • DOA rep • DCCED rep • DOL rep • 3 public members (1 small business owner) • House ex-officio. • Senate ex-officio. • Gov. office ex-officio July 1 effective date		Changes composition of the Health Care Commission: 12 members • DHSS Med. Officer (Chair) • DOA rep • DCCED rep • DOL rep • 6 public members (1 small business owner) • House representative • Senate representative	Changes composition of the Health Care Commission: 12 members: • DHSS Med. Officer (Chair) • DOA rep • DCCED rep • DOL rep • 6 public members (1 small business owner) • House representative • Senate representative July 1 effective date **Page 3, line 22 (3s on commission** **Page 3 line 5 and 7 removing ex-officio of legislative members**
Creates **Health Info office**: health info on web site on health care facilities, costs on health care, licensed facilities. July 1 effective date	Modifies info gathered, but no great impact on intent	Modifies info gathered to focus on: • Access to health care. • Cost of health care • Quality of health care	Modifies info gathered to focus on: • Access to health care. • Cost of health care • Quality of health care **Page 6, line 12-26**
Repeals Certificate of Need, immediate effective date	Eliminates all CON Except Delays repeal of CON for 2 years for: • Nursing Homes • RPTC • Critical Access Hospitals (does not protect such hospitals from HDF or Amb. Surgery centers, need to address Communities which have such facilities)	Eliminates all CON Except DOES NOT repeal of CON for: • Nursing Homes • RPTC • Critical Access Hospitals (does not protect such hospitals from HDF or Amb. Surgery centers, need to address Communities which have such facilities) (note: No end date, relies on solutions or recommendations from Commission)	Eliminates all CON Except DOES NOT repeal of CON for: • Nursing Homes • RPTC • Critical Access Hospitals (does not protect such hospitals from HDF or Amb. Surgery centers, need to address Communities which have such facilities) **Page 3, lines 1-10**

Other legislation, CON only:

HB4 (Rep. Lynn)	HB 345	CS for HB337
Eliminates CON except for • Health care facilities in boroughs having a population of not more than 25,000 OR in a community with a critical access hospital • Nursing Homes • RPTC	Retains CON, except makes the following CON changes: Excludes CON for Diagnostic Imaging Equipment located in: • A borough of population of 60,000 or more AND • A city that does not have a critical access hospital AND • Has at least 50% ownership by one or more licensed, qualified AK physicians	Eliminates all CON Except DOES NOT repeal of CON for: • Nursing Homes • RPTC • Critical Access Hospitals (does not protect such hospitals from HDF or Amb. Surgery centers, need to address Communities which have such facilities) **Page 3, lines 1-10**

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Creates **Health Info office**: health info on web site on health care facilities, costs on health care, licensed facilities. July 1 effective date	Modifies info gathered, but no great impact on intent	Modifies info gathered to focus on: • Access to health care. • Cost of health care • Quality of health care	Modifies info gathered to focus on: • Access to health care. • Cost of health care • Quality of health care **Page 6, line 12-26**
Repeals Certificate of Need, immediate effective date	Eliminates all CON Except Delays repeal of CON for 2 years for: • Nursing Homes • RPTC • Critical Access Hospitals (does not protect such hospitals from HDF or Amb. Surgery centers; need to address Communities which have such facilities)	Eliminates all CON Except DOES NOT repeal of CON for: • Nursing Homes • RPTC • Critical Access Hospitals (does not protect such hospitals from HDF or Amb. Surgery centers; need to address Communities which have such facilities) (note: No end date, relies on solutions or recommendations from Commission)	Eliminates all CON Except DOES NOT repeal of CON for: • Nursing Homes • RPTC • Critical Access Hospitals (does not protect such hospitals from HDF or Amb. Surgery centers; need to address Communities which have such facilities) **Page 3, lines 1-10**

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AAC 07.050, 7 AAC 07.052, 7 AAC 07.060, 7 AAC 07.067, 7 AAC 07.070, 7 AAC 07.072, 7 AAC 07.079, 7 AAC 07.080, 7 AAC 07.092, 7 AAC 07.095, 7 AAC 07.105, 7 AAC 07.107, and 7 AAC 07.900;

(2) 7 AAC 09.030(3) and 7 AAC 09.170(5);

(3) 7 AAC 43.689(g)(4)(B);

(4) 15 AAC 118.020(c)(3) and (d)(1).

(b) The commissioner of health and social services shall immediately proceed under AS 44.62 to amend or annul the following regulations in accordance with the provisions of this Act:

(1) 7 AAC 09.020;

(2) 7 AAC 43.679, 7 AAC 43.685, 7 AAC 43.686, and 7 AAC 43.709.

*** Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: PENDING APPLICATIONS, ADMINISTRATIVE APPEALS, AND COURT ACTIONS FOR THE CERTIFICATE OF NEED PROGRAM. (a) The commissioner of health and social services through the Department of Law shall immediately take steps to seek dismissal of pending administrative appeals and court actions concerning the issuance of certificates of need under AS 18.07 or implementation of AS 18.07.

(b) The Department of Health and Social Services shall immediately close all pending application files under AS 18.07. The Department of Health and Social Services shall send written notification to applicants of the action taken under this subsection.

*** Sec. 11.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 12.** Sections 5, 6, and 8 - 10 of this Act take effect July 1, 2010.

*** Sec. 13.** Except as provided in sec. 12 of this Act, this Act takes effect July 1, 2008.

MEMORANDUM

DATE: **January 25, 2008**
TO: **Senator Bettye Davis**
FROM: **Thomas S. Obermeyer**
RE: **SB 245** – " An Act establishing the Alaska Health Care Commission and the Alaska Health Care Information Office; relating to health care planning and information; repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date." –also known as the "Health care Transparency Act –or Initiative"

Summary

I. This bill attempts to combine three substantive areas of health care into one bill:

1) Creation of a statewide health care plan
2) Establish a 10-member Alaska Health Care Commission with Executive Director to be partially exempt
3) Repeal Certificate of Need program (CON)
   A. Dismiss pending administrative appeals and court actions regarding CON. – allow transition to 7/1/2010.
   B. Allow continuation of "certain health care facilities," defined as critical care hospitals, nursing homes, and residential psychiatric treatment centers

II. Sections 1, 2, and 5 of SB 245 are to take effect immediately, *i.e.*, July 1, 2008.

III. Sections, 3,4, and 6-10 to repeal CON take effect immediately, with exceptions for pending appeals and litigation extended to 7/1/2010, and continuation of "certain health care facilities" defined per above to include critical care hospitals, nursing homes and psychiatric treatment facilities.

Sectional Analysis

The Sectional Analysis of SB245/HB337 by the Department of Health and Social Services is to be changed per the amendments as follows:

Section 1. No change to plan to create Alaska Health Care Commission

(section to take effect July 1, 2008)

Section 2. No change to first part regarding policy, strategy and new Alaska Health Care Information Office.
Major change in last section, AS 18.09.110, regarding department information related to health care facilities, pharmacies, drugs, etc. This section is completely rewritten, much more detailed, and demanding.

Note that amendment eliminates need for update of Internet website (which could save $800,000 in fiscal note #1 out of $1,205,600. Elimination of website does not make sense as it is integral to program. Perhaps it is included in another part of the bill which I have not discovered.
Section to take effect July 1, 2008)

Sections 3 & 4. No changes, except on page 8, additions to definitions of "health care facility" to mean: A) a facility licensed under AS 47.32; B) an independent diagnostic testing facility providing services in the state; and per amendment, C) provider of home and community-based waiver service certified by state; and D) provider of personal care services that is certified under regulations of the department.

Section 5. No change in executive director classified as partially exempt.
(section to take effect July 1, 2008)

Section 6. No change in repeal of CON program.

Section 7. No change in annulling regulations governing the Certificate of Need Program, except for typo change.

Section 8. Allows until July 1, 2010 for Commission of HSS and Dept. of Law to dismiss pending administrative appeals and court actions concerning CON.

Section 9. Completely replace with "Transition: Continuation of certificate of need requirements for 'certain health care facilities'" defined above to include critical care hospitals, nursing homes and psychiatric treatment facilities.

Section 10. Renumbered sections to take effect immediately: 3, 4, and 6-10.

Section 11. Sections 1,2, an5 to take effect July 1, 2008.

Fiscal Notes

Fiscal Note 1: FY 2009 requires appropriation of $1,205,600 and about $200,000 higher for FY 2010-2013. If Internet website eliminated per amendment,, i.e., line 17, page 7 (C), savings could be $800,000 and part of 4 personnel.
Repeal of CON results in savings of $3 million per year in payments for avoided capital costs (50% federa/50%GF/M). This represents 1.2% of total project costs for these facilities.
Page 2 details summary of expenditures and savings.

Fiscal Note 2:

Costs $800,100 for FY 2009 and similar through 2013 to create and man Alaska Health Care Information Office and related website. Costs could be lower and fewer than the 2 personnel if website eliminated, but this may not be necessary or intended as I read the bill.
Detail summary of expenditures and savings, fiscal note 2, page 2 is identical to fiscal note 1, page 2.

Fiscal Note 3.

Eliminates CON program; saves $304,600 and eliminates 2 positions.
Detail summary of expenditures and savings, fiscal note 3, page 2 is identical to fiscal notes 1 and 2, page 2.

Fiscal Note 4.

Establishes cost of Alaska Health Care Commission at $710,100, including 2 FT positions.

Detail summary of expenditures and savings, fiscal note 4, page 3 is identical to fiscal notes 1,2 and 3, page 2.

25G-2
1/24/2008
(1:42 pm)

AMENDMENT

OFFERED IN THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

BY _____

TO: SB 245

Page 6, lines 5 - 16:

Delete all material and insert:

"(1) the list of preferred drugs approved by the department for reimbursement by the department;

(2) a complete list, organized by region and address, of

(A) health facilities located in the state;

(B) licensed pharmacists and pharmacies located in the state;

(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state;

(G) public assistance offices of the department;

(3) a list of the 100 most commonly prescribed medications in the state and the source and price, updated monthly, of the medications;

(4) a list of the 100 most commonly conducted medical procedures in the state, organized by the cash and negotiated price of the procedure at available providers and insurers, updated annually; the list must include medical procedures covered by workers' compensation under AS 23.30;

(5) available hospital ratings, including the rates of hospital-acquired infections and mortality occurring at each hospital located in the state;

(6) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, and that includes the location of available sites that provide care and treatment;

(7) a list of procedures approved by state agencies for emergency response and treatment;

(8) disease management support information;

(9) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

(B) links to Internet websites for purchasing insurance policies; and

(C) an explanation of mandatory and optional insurance coverage;

(10) a list of primary care clinics that cater to uninsured and self-pay patients; and

(11) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility.

(c) The department may contract with a private entity to provide services and information required under (b) of this section."

Page 6, line 17:

Delete "(c)"

Insert "(d)"

Page 6, line 20:

Delete "(d)"

Insert "(e)"

Page 8, line 6:

Delete "."

Insert ";"

Page 8, following line 6:

Insert

"(C) a provider of a home and community-based waiver service that is certified under regulations of the department;

(D) a provider of personal care services that is certified under regulations of the department."

Page 8, line 23:

Delete "AS 47.32."

Insert "AS 47.32,"

Page 9, line 28:

Delete "7 AAC 09.030(b)(3)"

Insert "7 AAC 09.030(3)"

Page 10, following line 15:

Insert a new bill section to read:

"* Sec. 9. The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: CONTINUATION OF CERTIFICATE OF NEED REQUIREMENTS FOR CERTAIN HEALTH CARE FACILITIES. (a) Notwithstanding sec. 6 of this Act, the provisions of former AS 18.07.021, 18.07.031, 18.07.035, 18.07.041, 18.07.043, 18.07.045, 18.07.051, 18.07.061, 18.07.071, 18.07.081, 18.07.091, 18.07.101, 18.07.111; and AS 47.80.140(b) continue in effect as they read on June 30, 2008 for certain health care facilities as defined in (e) of this section.

(b) Notwithstanding sec. 7(a) of this Act, the provisions of the following regulations continue in effect as they read on June 30, 2008 for certain health care facilities defined in (e) of

this section:

(1) 7 AAC 07.010, 7 AAC 07.012, 7 AAC 07.015, 7 AAC 07.025, 7 AAC 07.031, 7 AAC 07.032, 7 AAC 07.033, 7 AAC 07.035, 7 AAC 07.040, 7 AAC 07.042, 7 AAC 07.050, 7 AAC 07.052, 7 AAC 07.060, 7 AAC 07.067, 7 AAC 07.070, 7 AAC 07.072, 7 AAC 07.079, 7 AAC 07.080, 7 AAC 07.092, 7 AAC 07.095, 7 AAC 07.105, 7 AAC 07.107, and 7 AAC 07.900;

(2) 7 AAC 09.030(3) and 7 AAC 09.170(5);

(3) 7 AAC 43.689(g)(4)(B);

(4) 15 AAC 118.020(c)(3) and (d)(1).

(c) Notwithstanding sec. 8 of this Act, the commissioner of health and social services may not immediately take the actions required by sec. 8 of this Act for the certain health care facilities until July 1, 2010.

(d) The provisions of this section apply only until June 30, 2010.

(e) In this section,

(1) "certain health care facilities" means

(A) critical access hospitals;

(B) nursing homes;

(C) residential psychiatric treatment centers;

(2) "critical access hospital" means a facility that is a hospital licensed in this state that satisfies the criteria set out at 42 U.S.C. 1395i-4(c)(2)(B) and meets the conditions of participation set out in 42 C.F.R. 485.601 - 485.647;

(3) "nursing home" means a nursing facility as defined in 42 U.S.C. 1396r(a);

(4) "residential psychiatric treatment center" means a secure or semi-secure psychiatric facility or inpatient program in a psychiatric facility that is licensed by the Department of Health and Social Services and that provides therapeutically appropriate and medically necessary diagnostic, evaluation, and treatment services

(A) 24 hours a day for children with severe emotional or behavioral disorders;

(B) under the direction of a physician; and

(C) under a professionally developed and supervised individual plan of care that is designed to achieve the recipient's discharge from inpatient status at the

earliest possible time, and that is intensively and collaboratively delivered by an interdisciplinary team involving medical, mental health, educational, and social service components."

Renumber the following bill sections accordingly.

Page 10, line 22:

Delete "Sections 3, 4, 6 - 8, and 9"

Insert "Sections 3, 4, and 6 - 10"

Page 10, line 24:

Delete "sec. 10"

Insert "sec. 11"

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 245
(S) Publish Date: 1/19/08

ID(File name) 0050-DHSS-MS-1-18-08
Title HEALTH CARE TRANSPARENCY ACT
Sponsor RULES COMMITTEE
Requester

Dept. Affected: Health & Social Services
RDU Health Care Services
Component Medicaid Services
Component No. 2077

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	•		•	•	•	•	•
Miscellaneous							
TOTAL OPERATING	•	**0.0**	•	•	•	•	•
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	•		•	•	•	•	•
1003 GF Match	•		•	•	•	•	•
1004 GF							
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	•	**0.0**	•	•	•	•	•

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

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

This bill eliminates the Certificate of Need program. This fiscal note is indeterminate. Eliminating the CON program would likely increase costs to Medicaid, however the costs are unknown at this time.

This fiscal note is based on projects denied, withdrawn, or reduced as the result of the CON program which is estimated to have saved the Alaska Medicaid program approx. $3 million per year in payments for avoided capital costs (50% federal/50% GF/M). This represents 1.2% of the total project costs for these facilities.

Prepared by: William Streur, Deputy Commissioner — Phone 465-5830
Division Health Care Services — Date/Time 01/16/2008
Approved by: Karleen Jackson, Commissioner — Date 01/18/2008
Agency Department of Health and Social Services

FISCAL NOTE
FN # 1

STATE OF ALASKA
2008 LEGISLATIVE SESSION

BILL NO. SB 245

ANALYSIS CONTINUATION

HEALTH CARE TRANSPARENCY INITIATIVE

Fiscal Note Summary by Component
Department of Health & Social Services

Dollars in thousands		Appropriation Required FY2009	Information FY2009	FY2010	FY2011	FY2012	FY2013
Total All Expenditures by Fund Source	Total	$1,205.6	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$1,420.7	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Health Care Services Medicaid Services Indeterminate additional cost to Medicaid if CON eliminated.	Total	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Departmental Support Svcs Health Planning & Infrastructure Savings if CON program is eliminated. Eliminates revenues from CON application fees.	Total	($304.6)	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	($89.5)	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Commissioner's Office AK Health Care Information Office Establishes new office in DHSS and Internet site to provide consumers information about all health care facilities in the state.	Total	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Boards & Commissions AK Health Care Commission Establish new commission in DHSS to develop statewide plan addressing the quality, accessibility and availability of health care in Alaska.	Total	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Total All Positions	Full time	4	0	4	4	4	4
Health Care Services Medicaid Services	Full time	0	0	0	0	0	0
Departmental Support Svcs Health Planning & Infrastructure	Full time	-2	0	-2	-2	-2	-2
Commissioner's Office AK Health Care Information Office	Full time	4	0	4	4	4	4
Boards & Commissions AK Health Care Commission	Full time	2	0	2	2	2	2

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: SB 245
(S) Publish Date: 1/19/08

ID(File name) 0050-DHSS-AHCIO-1-18-08
Title HEALTH CARE TRANSPARENCY ACT
Sponsor RULES COMMITTEE
Requester

Dept. Affected: Health & Social Services
RDU Commissioner's Office
Component AK Health Care Information Office
Component No. 2899

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services	494.9		494.9	494.9	494.9	494.9	494.9
Travel	18.0		18.0	18.0	18.0	18.0	18.0
Contractual	250.0		235.0	235.0	235.0	235.0	235.0
Supplies	22.2		10.0	10.0	10.0	10.0	10.0
Equipment	15.0		10.0	10.0	10.0	10.0	10.0
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**800.1**	**0.0**	**767.9**	**767.9**	**767.9**	**767.9**	**767.9**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	800.1		767.9	767.9	767.9	767.9	767.9
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	**800.1**	**0.0**	**767.9**	**767.9**	**767.9**	**767.9**	**767.9**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time	4		4	4	4	4	4
Part-time							
Temporary							

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

The bill creates the Alaska Health Care Information Office and a related Internet site to provide consumers consistently updated information about all health care facilities in the state.

71000 Personal Services Two information technology positions are being requested to design, develop, implement, and support the dissemination of information on the internet for all health care facilities in the state to provide objective, unbiased, and factually based information on those facilities. In addition, an interactive website will be created to assist the public in obtaining timely and accurate information about personal responsibility in preventing chronic health conditions and promoting healthy living. Two planner positions will be needed to assist in research and data collection for the Commission.

Prepared by: Jay C. Butler, MD
Division Chief Medical Officer
Approved by: Karleen Jackson, Commissioner
Agency Department of Health and Social Services

Phone 269-8045
Date/Time 01/17/2008
Date 01/18/2008

STATE OF ALASKA **BILL NO: SB 245**
2008 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Funding is needed to support two existing positions—Public Information Officer and Publications Technician. These positions will coordinate internal and external communications for the Alaska Health Care Information Office.

72000 Travel
Travel and per diem for professional staff.

73000 Contractual
Professional services contracts will be needed to facilitate and supplement formative research methods to develop and messages to promote healthy behaviors. Core Service RSAs will be required to provide lease space, telecommunications, mainframe connectivity, postage, etc.

74000 Supplies
In addition to day-to-day office supplies; FY09 includes one-time-only start-up costs such as computers, office furniture, reconfiguring leased space, wiring needs for connectivity, printers, fax, and photocopier.

75000 Equipment
FY09 includes a one-time-only purchase of a server; subsequent fiscal years provide for technology upgrades and maintenance.

A summary of the overall impact of this legislation follows on the next page.

FISCAL NOTE
FN # 2

STATE OF ALASKA
2008 LEGISLATIVE SESSION

BILL NO. SB 249

ANALYSIS CONTINUATION

HEALTH CARE TRANSPARENCY INITIATIVE

Fiscal Note Summary by Component
Department of Health & Social Services

Dollars in thousands		Appropriation Required FY2008	Information FY2009	FY2010	FY2011	FY2012	FY2013
Total All Expenditures by Fund Source	Total	$1,205.6	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$1,420.7	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Health Care Services Medicaid Services Indeterminate additional cost to Medicaid if CON eliminated.	Total	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Departmental Support Svcs Health Planning & Infrastructure Savings if CON program is eliminated. Eliminates revenues from CON application fees.	Total	($304.6)	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	($89.5)	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Commissioner's Office AK Health Care Information Office Establishes new office in DHSS and Internet site to provide consumers information about all health care facilities in the state.	Total	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Boards & Commissions AK Health Care Commission Establish new commission in DHSS to develop statewide plan addressing the quality, accessibility and availability of health care in Alaska.	Total	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Total All Positions	Full time	4	0	4	4	4	4
Health Care Services Medicaid Services	Full time	0	0	0	0	0	0
Departmental Support Svcs Health Planning & Infrastructure	Full time	-2	0	-2	-2	-2	-2
Commissioner's Office AK Health Care Information Office	Full time	4	0	4	4	4	4
Boards & Commissions AK Health Care Commission	Full time	2	0	2	2	2	2

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 3
Bill Version: SB 245
(S) Publish Date: 1/19/08

ID(File name) 0050-DHSS-HPI-1-18-08
Title HEALTH CARE TRANSPARENCY ACT
Dept. Affected: Health & Social Services
RDU Departmental Support Services
Component Health Planning & Infrastucture

Sponsor RULES COMMITTEE
Requester

Component No. 2765

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services	(190.1)						
Travel	(21.6)						
Contractual	(90.9)						
Supplies	(2.0)						
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**(304.6)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	(44.8)						
1003 GF Match	(44.8)						
1004 GF	(89.5)						
1037 GF/Mental Health							
1156 Receipt Support Svcs (RSS)	(125.5)						
Other(Specify Type-do not abbreviate)							
TOTAL	**(304.6)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time	- 2						
Part-time							
Temporary							

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

This bill eliminates the Certificate of Need program. These sections take effect immediately so FY09 is for a full year. This fiscal note estimates the savings in personal services and other administrative costs from elimination of the Certificate of Need office in Health Planning & Infrastructure. Expenditures are based on FY07 actuals and include legal services for CON hearings & appeals. Two positions would be eliminated. Revenue from CON application fees would be eliminated (all of Receipt Support Services). Revenue estimates for RSS are based on FY08 Managment Plan and the remainder is pro-rated at 50% Medicaid reimbursable/50% non-reimbursable. The Medicaid costs are 50% federal/50% GF Match.

A summary analysis of the impacts of this legislation follows on next page.

Prepared by: Dr. Jay Butler, Chief Medical Officer — Phone 269-7800
Division Commissioner's Office — Date/Time 01/16/2008
Approved by: Karleen Jackson, Commissioner — Date 01/18/2008
Agency Department of Health and Social Services

FISCAL NOTE
FN # 3

STATE OF ALASKA
2008 LEGISLATIVE SESSION

BILL NO. SB 245

ANALYSIS CONTINUATION

HEALTH CARE TRANSPARENCY INITIATIVE

Fiscal Note Summary by Component
Department of Health & Social Services

Dollars in thousands		Appropriation Required FY2009	Information FY2009	FY2010	FY2011	FY2012	FY2013
Total All Expenditures by Fund Source	Total	$1,205.6	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$1,420.7	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Health Care Services Medicaid Services Indeterminate additional cost to Medicaid if CON eliminated.	Total	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Departmental Support Svcs Health Planning & Infrastructure Savings if CON program is eliminated. Eliminates revenues from CON application fees.	Total	($304.6)	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	($89.5)	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Commissioner's Office AK Health Care Information Office Establishes new office in DHSS and Internet site to provide consumers information about all health care facilities in the state.	Total	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Boards & Commissions AK Health Care Commission Establish new commission in DHSS to develop statewide plan addressing the quality, accessibility and availability of health care in Alaska.	Total	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Total All Positions	Full time	4	0	4	4	4	4
Health Care Services Medicaid Services	Full time	0	0	0	0	0	0
Departmental Support Svcs Health Planning & Infrastructure	Full time	-2	0	-2	-2	-2	-2
Commissioner's Office AK Health Care Information Office	Full time	4	0	4	4	4	4
Boards & Commissions AK Health Care Commission	Full time	2	0	2	2	2	2

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 4
Bill Version: SB 245
(S) Publish Date: 1/19/08

ID(File name) 0050-DHSS-AHCC-1-18-08
Title HEALTH CARE TRANSPARENCY ACT
Dept. Affected: Health & Social Services
RDU Boards & Commissions
Component AK Health Care Commission

Sponsor RULES COMMITTEE
Requester
Component No. 2900

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services	173.1		173.1	173.1	173.1	173.1	173.1
Travel	200.0		200.0	200.0	200.0	200.0	200.0
Contractual	250.0		250.0	250.0	250.0	250.0	250.0
Supplies	72.0		10.0	10.0	10.0	10.0	10.0
Equipment	15.0		10.0	10.0	10.0	10.0	10.0
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**710.1**	**0.0**	**643.1**	**643.1**	**643.1**	**643.1**	**643.1**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	710.1		643.1	643.1	643.1	643.1	643.1
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	**710.1**	**0.0**	**643.1**	**643.1**	**643.1**	**643.1**	**643.1**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time	2		2	2	2	2	2
Part-time							
Temporary							

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

This bill permanently establishes the Alaska Health Care Commission in DHSS to develop a statewide plan addressing the quality, accessibility and availability of health care in Alaska.

71000 Personal Services: Two new positions are needed to support the Commission. Costs are esetimated for an Executive Director and administrative support position.

72000 Travel: Travel and per diem for Commission staff; and, travel and per diem for ten Commission members to conduct public meetings around the state.

Prepared by: Jay C. Butler, MD
Division Chief Medical Officer
Phone 269-8045
Date/Time 01/17/2008

Approved by: Karleen Jackson, Commissioner
Agency Department of Health and Social Services
Date 01/18/2008

ANALYSIS CONTINUATION

73000 Contractual

Professional services contracts will be needed to supplement staff research and core service RSAs will be required to provide lease space, telecommunications, mainframe connectivity, postage, etc.

74000 Supplies

In addition to day-to-day office supplies; FY09 includes one-time-only start-up costs such as computers, office furniture, reconfiguring leased space, wiring needs for connectivity, printers, fax, and photocopier.

75000 Equipment

FY09 includes a one-time-only purchase of a server; subsequent fiscal years provide for technology upgrades and maintenance

A summary of the overall impact of this legislation follows on next page.

FISCAL NOTE
FN # 4

STATE OF ALASKA
2008 LEGISLATIVE SESSION

BILL NO. SB 245

ANALYSIS CONTINUATION

HEALTH CARE TRANSPARENCY INITIATIVE

Fiscal Note Summary by Component
Department of Health & Social Services

Dollars in thousands		Appropriation Required FY2009	Information FY2009	FY2010	FY2011	FY2012	FY2013
Total All Expenditures by Fund Source	Total	$1,205.6	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$1,420.7	$0.0	$1,411.0	$1,411.0	$1,411.0	$1,411.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Health Care Services Medicaid Services Indeterminate additional cost to Medicaid if CON eliminated.	Total	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Departmental Support Svcs Health Planning & Infrastructure Savings if CON program is eliminated. Eliminates revenues from CON application fees.	Total	($304.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	Federal	($44.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	($14.8)	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	($89.5)	$0.0	$0.0	$0.0	$0.0	$0.0
	RSS	($125.5)	$0.0	$0.0	$0.0	$0.0	$0.0
Commissioner's Office AK Health Care Information Office Establishes new office in DHSS and Internet site to provide consumers information about all health care facilities in the state.	Total	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$800.1	$0.0	$767.9	$767.9	$767.9	$767.9
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Boards & Commissions AK Health Care Commission Establish new commission in DHSS to develop statewide plan addressing the quality, accessibility and availability of health care in Alaska	Total	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	Federal	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF Match	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
	GF	$710.1	$0.0	$643.1	$643.1	$643.1	$643.1
	RSS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Total All Positions	Full time	4	0	4	4	4	4
Health Care Services Medicaid Services	Full time	0	0	0	0	0	0
Departmental Support Svcs Health Planning & Infrastructure	Full time	-2	0	-2	-2	-2	-2
Commissioner's Office AK Health Care Information Office	Full time	4	0	4	4	4	4
Boards & Commissions AK Health Care Commission	Full time	2	0	2	2	2	2

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

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

Sectional Analysis
SB 245/HB 337 Health Care Transparency Act

Section 1. AS 18.05.010(b)

Requires the Department of Health and Social Services to implement a statewide health plan under AS 18.09, which is a new chapter creating the Alaska Health Care Commission.

Sec. 2. AS 18.09

Establishes a 10-member Alaska Health Care Commission within the Department of Health and Social Services. The purpose of the Commission is to develop a statewide plan to address the quality, accessibility and availability of health care for all citizens of the state; and to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Section 2 also specifies that the plan contain a health care policy and a strategy for encouraging: personal responsibility and reductions in health care costs; access to safe water and wastewater systems; development of a sustainable health care workforce; accessible quality health care; and an increase in the number of residents who are covered by insurance.

Establishes an Alaska Health Care Information Office to provide consistently updated health care facility information to aid consumers of health care serves, and information to encourage personal responsibility in prevention and healthy living.

Finally, the section requires health care facilities to provide the department information related to the facility's health care services for placement on the database developed under AS 18.09.110.

Sec. 3. AS 18.26.220 and Sec. 4 AS 21.86.030(c)

Technical, conforming edits to reflect the repeal of the CON program (see Sec. 6).

Sec. 5 AS 39.25.120(c)(7)

Specifies that the principal executive officer of the Alaska Health Care Commission is classified as partially exempt.

Sec. 6

Repeals 18.07, the Certificate of Need Program; and 47.80.140(b), which requires a certificate of need as a prerequisite for licensing a residential facility after July 1, 1978.

Sec. 7.

Annuls regulations governing the Certificate of Need Program.

Revised: 1/24/2008

Sec. 8

Directs the commissioner of the Department of Health and Social Services and Department of Law to immediately take steps to seek dismissal of pending administrative appeals and court actions concerning the issuance of certificates of need under AS 18.07. Requires the Department of Health and Social Services to immediately close all pending application files under AS 18.07.

Sec. 9

Allows the Department of Health and Social Services to adopt regulations necessary to implement changes made by this Act.

Sec. 10

Sets an immediate effective date for:

Section 3 and 4, technical amendments to reflect repeal of certificate of need program;

Section 6, repealing 18.07, certificate of need program;

Section 7, annulling regulations governing the certificate of need program;

Section 8, dismissing pending administrative appeals and court actions; and closing all pending application files under the certificate of need program;

Section 9, allowing the department to adopt regulations to implement changes made in the act.

Sec. 11

Sets an effective date of July 1, 2008 for:

Section 1, requiring the department to implement a statewide health plan;

Section 2, establishing the Alaska Health Care Commission and the Alaska Health Care Information Office;

Section 5, specifying the executive officer of the Health Care Commission as partially exempt.



FOR IMMEDIATE RELEASE **No. 08-006**

Governor Palin Introduces the Health Care Transparency Act

January 19, 2008, Juneau, Alaska - Governor Sarah Palin today introduced the Alaska Health Care Transparency Act which will provide more effective tools to help Alaskans access affordable health care, and to ensure our health care system is responsive to changing demographics and market conditions.

The Act includes some recommendations from the Health Care Strategies Planning Council and the Health and Social Services Certificate of Need Negotiated Rule Making Committee.

"I thank the members of these two committees," Governor Palin said. "They worked diligently to evaluate the broad spectrum of the health care system in our state. After reviewing their work, I am establishing the Alaska Health Care Commission to further health care planning from a statewide perspective, by building on the work they have done."

The bill would establish an Alaska health care information office to give consumers factual information on quality, cost and other important matters to help them make better-informed decisions about health care in the state. Recognizing that health care must be market-and business-driven, rather than restricted by government, Governor Palin is proposing a repeal of the Certificate of Need program (CON).

CON is a regulatory process that requires certain health care providers to obtain state approval before offering certain new or expanded services.

Health and Social Services Commissioner Karleen Jackson concluded that the CON program does not benefit the citizens of Alaska, given the litigious environment surrounding it.

The reports from the two committees are available online at:
http://www.hss.state.ak.us/commissioner/legislature/

###

DHSS Contacts: Sherry Hill (907) 465-1618, cell (907) 321-2838
Wilda Laughlin (907) 465-1613, cell (907) 723-3802

Senate Bill - 245 Date: 2-14-8

Senator Bettye Davis

Fax: 907-465-3756 1-800-770-3822

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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 as imposed on the health care in Alaska.

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Bree Barnes
Signature: Bree Barnes
Address: PO Box 74197 Fairbanks, AK 99707
Telephone: 540-239-8197

Senate Bill - 245 **Date:** 2/14/8

Senator Bettye Davis

Fax: 907-465-3756 1-800-770-3822

RE: Elimination of the Certificate of Need (CON)

RECEIVED
FEB 14 2008

Yes, I support Governor Palin's 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 as imposed on the health care in Alaska.

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Stephanie Clemons
Signature: [signature]
Address: 1236 Hayes Ave FBKS AK 99709
Telephone: 455-9516

Senate Bill - 245 **Date:** 2/14/8

Senator Bettye Davis

Fax: 907-465-3756 1-800-770-3822

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Stephanie Clemons
Signature: [signature]
Address: 1236 Hayes Ave Fbks AK 99709
Telephone: 455-9516

Senate Bill - 245 Date: 2/1/08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Shannon Williams
Signature: Shannon Williams
Address: 1704 Skyflight Ave, Fairbanks, AK 99709
Telephone: (907) 452-7989

Senate Bill - 245 Date: 2-4-2008

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Carla E. Long
Signature: Carla E. Long
Address: 3715 Geist Rd Ste C #151 Fairbanks, AK
Telephone: 907-451 9201

Feb 05 08 11:28p Wayne & Linda Long 907-457-2928 p.1

Senate Bill - 245

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's 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.

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

Thank you for your support.

Signature Kathleen Bolle

Senate Bill - 245

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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

Thank you for your support.

Signature Lisa Pate

Senate Bill - 245 **Date:** _____

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Angela Radvenz
Signature: A. J Radvenz
Address: 2297 Outside Blvd N. Pole
Telephone: 907-488-4673

Senate Bill - 245 **Date:** 1-28-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Robert A Thomason
Signature: Robert A Thomason
Address: 224 North F Street, Nenana AK 99760
Telephone: 907.378.6123

Senate Bill - 245 **Date:** 1-28-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Robin W. Foster
Signature:
Address: 4318 W. Tudor
Telephone: 479-6172

Senate Bill - 245

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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

Thank you for your support.

Signature _____

Travis Finendale

Senate Bill - 245

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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

Thank you for your support.

Signature Lydia Tschumy

Senate Bill - 245 **Date:** 1-28-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Jenni M. Middleton
Signature: Jenni M. Middleton
Address: 431 Grange Hall Rd FBKS, AK 9971
Telephone: (907) 488-5317

Senate Bill - 245
Senator Bettye Davis
Fax: 907-465-3756

Date: 1-28-08

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Dianne J Andrews
Signature: Dianne J. Andrews
Address: 330 3rd Ave #407 Fairbanks, AK 99701
Telephone: 907-451-0347

Senate Bill - 245 **Date:** 1/28/08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Patrick Rollig
Signature: [signature]
Address: 1020 Wilbert Fairbanks AK 99712
Telephone: 457-4012

Senate Bill - 245 **Date:** 1/25/08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: MICHELE BIFELI
Signature: [signature]
Address: 2235 BUZBY RD NORTH POLE AK
Telephone: 488-4891

Senate Bill - 245 Date: 1-22-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Dianne M Williams
Signature: Dianne M Williams
Address: P.O. Box 55755, N.P. AK 99705
Telephone: 490-0021

Senate Bill - 245 Date: 1-29-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Betty Dahlke
Signature: Betty Dahlke
Address: P.O. Box 56233, North Pole, AK 99705
Telephone: 488-3974

Senate Bill - 245 Date: 1-29-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Donna Grimes
Signature: Donna Grimes
Address: PO Box 251, Nenana, AK 99760
Telephone: 832-2400 x 218

Senate Bill - 245 **Date:** 1-29-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Dan Guzy
Signature: Dan Guzy
Address: 3307 Bekel Rd NP AK 99705
Telephone: 488-2471

Senate Bill - 245 Date: 1-29-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Michael Andrus
Signature: Michael Andrus
Address: P.O. Box 81342 Fbks AK 99708
Telephone: (907) 347-9796

Senate Bill - 245 Date: 1-29-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Anne Sherman
Signature: Anne Sherman
Address: 3467 Shanly
Telephone: 479-2772

Senate Bill - 245 Date: 1/29/08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Charles Mason
Signature: [signature]
Address: 4760 Val View Dr Fairbanks AK 99712
Telephone: 457-9074

Senate Bill - 245 **Date:** 1-24-05

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Susan Ringstrom
Signature: [signature]
Address: 6235 Birch Ln
Telephone: 458-8384

Senate Bill - 245 **Date:** 1-29-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Emily A. Roberts
Signature: [signature]
Address: PO Box 709101 Fairbanks, AK 99707
Telephone: 907-750-0722

Senate Bill - 245 **Date:** 1-30-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Cindy Lamoureux
Signature: Cindy Lamoureux
Address: P.O. Box 82815, Fairbanks, AK 99708
Telephone: 907-452-4110

Senate Bill - 245 Date: 1-30-09

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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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 am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Virgil Lamoureux
Signature: Virgil Lamoureux
Address: P.O. Box 97615 FBKS AK
Telephone: 456-2489

Senate Bill - 245 **Date:** 1-29-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: PATRICIA FOGGIA
Signature: Patricia Foggia
Address: 1512 28TH AVE FAIRBANKS AK 99701
Telephone: 907-457-5566

Senate Bill - 245 **Date:** 1-29-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: STANLEY FOGGIA
Signature: Stanley Foggia
Address: 1512 28TH AVE FAIRBANKS AK 99701
Telephone: 907-457-5566

Senate Bill - 245 Date: 2-19-08

Senator Bettve Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: WILLIAM D TANNER
Signature: William D Tanner
Address: 1501 HUSKY WAY FAIRBANKS, AK 99709
Telephone: 907 479-2779 H 452-5121 W

Senate Bill - 245 Date: 2-18-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Sidney Childers
Signature: Sidney Childers
Address: 1010 College Rd Fbk. 99701
Telephone: 456-4510 (907)

Senate Bill - 245 Date: 2/19/08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Vicki Mohn
Signature: [signature]
Address: PO Box 74203
Telephone: 452-1049

Senate Bill - 245 **Date:** 1-29-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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 as imposed on the health care in Alaska.

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Joan Brandon Rezek
Signature: Joan Brandon Rezek
Address: 4048 Dunlap Avenue, Foks 99709
Telephone: 907-479-6066

Senate Bill - 245 Date: 1-29-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Deborah K O'Leary
Signature: Deborah K O'Leary
Address: 1926 Holmes rd North Pole AK
Telephone: 907-388-9344

Senate Bill - 245 Date: 1·29·08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Jessica Reeck
Signature: [signature]
Address: 1038 Dunlap Avenue, Fairbanks, AK 99709
Telephone: 907 479 6026

Senate Bill - 245 **Date:** 11/29/08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: JAMES L CABE
Signature: James L Cabe
Address: 273 W 7TH AVE, N.P, AK 99705
Telephone: 907 488 2994

Senate Bill - 245 **Date:** 1-30-09

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Michele Deckard
Signature: Michele Deckard
Address: 607 Old Steese Hwy Ste B PMB 723 FBKS, A
Telephone: 907 347 3176

Senate Bill - 245 **Date:** 1.29.08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: KATHRYN M WILSON
Signature: Kathryn M. Wilson
Address: PO Box 82144 Fairbanks, AK. 99708-2
Telephone: 907-479-7017

Senate Bill - 245 **Date:** 30 Jan 08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Donna R. LEWIS
Signature: Donna R. Lewis
Address: P.O. Box 58373, FBKS, AK 99711
Telephone: 907 978-7454

Senate Bill - 245 Date: 1-30-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Rand Roscrans
Signature: [signature]
Address: PO Box 97 Galena 99741
Telephone: 656 4503

Senate Bill - 245 **Date:** 30 Jan 2008

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Carmen D. McCumby
Signature: Carmen D. McCumby
Address: 154 View Ave Fairbanks AK 99712
Telephone: 907 457-5617

Senate Bill - 245 **Date:** 30 Jan. 2008

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Donald B. McCumby
Signature: Donald B McCumby
Address: 754 View Ave Fbks, AK 99712
Telephone: 457-5617

Senate Bill - 245 Date: 1/30/08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Sheila Des Rivieres
Signature: Sheila Des Rivieres
Address: 2084 Jackson St., Apt #1, North Pole, AK 99705
Telephone: 907-488-7997

P.01

TRANSACTION REPORT

JAN-30-2008 WED 04:11 PM

FOR: Senator Bettye Davis 9074653758

RECEIVE

DATE	START	SENDER	RX TIME	PAGES	TYPE	NOTE	M#	DP
JAN-30	04:09 PM		2'29"	7	FAX RX	OK		

Senate Bill - 245 **Date:** 1-29-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Erland Lanamen
Signature: Erland Lanamen
Address: 2131 Flight St. North Pole
Telephone: 488-6643

Senate Bill - 245 **Date:** 1-29-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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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 as imposed on the health care in Alaska.

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Jay Thomas Wiest
Signature: J. Thomas
Address: 1225 2nd Ave Fbks AK 99701
Telephone: 907- 458-0292

Senate Bill - 245 Date: 1-29-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Paul Jurgens
Signature: Paul Jurgens
Address: PO Box 370886
Telephone: N Pole AK 99705

Senate Bill - 245 Date: January 29 2008

Senator Bettye Davis

Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: CATHLEEN DOYLE

Signature: [signature]

Address: PO BOX 83391 FAIRBANKS ALASKA 99708

Telephone: 907 455-8159

Senate Bill - 245 Date: 1/29/08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Patsy Underwood
Signature: Patsy Underwood
Address: 1616 College Rd., Fbks AK, 99709
Telephone: 907-458-9230

Senate Bill - 245 Date: 1-28-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: DORENE WALRATH
Signature: Dorene Walrath
Address: PO Box 85123, 1410 3rd Fbks 99708
Telephone: 907-474-8770

Senate Bill - 245 **Date:** _____

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Daniel Long
Signature: [signature]
Address: 657 Farmers Loop Rd #2 Fairbanks, Ak 9972
Telephone: 907-457-2928

Senate Bill - 245 **Date:** _____

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Tim Cowb
Signature: _____
Address: P.O. Box 91678
Telephone: 347-2577

Senate Bill - 245 **Date:** _____

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Philip Long
Signature: _____
Address: 530 Basta Dr North pole AK 99705
Telephone: 907 488-9573

Senate Bill - 245

Date: 2-3-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Robert Ahlquist
Signature: Robert Ahlquist
Address: 1120 Gilmore Tr. Fairbanks, AK 99712
Telephone: 907-457-3258

Senate Bill - 245 Date: 2-1-09

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Ruth Ewig
Signature: (Ruth Ewig
Address: 2325 - 30th Avenue, Fairbanks, AK 99701
Telephone: (907) 452-5538

Senate Bill - 245 Date: 2-3-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's 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.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Vaughn Ewing
Signature: Vaughn Ewing
Address: 2325 30th Avenue
Telephone: 452-5938

Senate Bill - 245 Date: 2-1-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Laura Harper
Signature: Laura Harper
Address: 2518 Aster Dr., North Pole, AK
Telephone: 488-2520

Senate Bill - 245
Senator Bettye Davis
Fax: 907-465-3756

Date: Feb 1, 2015

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Michael Harper
Signature: Michael Harper
Address: 2515 Aster Dr North Pole AK 99705
Telephone: 907 488-2520

Senate Bill - 245 Date: 1-31-08

Senator Bettye Davis

Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's 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.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Joe J. Heath

Signature: Joe J. Heath

Address: P.O. Box 10744 Juneau, Ak 9971

Telephone: 907-457-8002

Senate Bill - 245 **Date:** 1/31/08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Melissa Belt
Signature: Melissa Belt
Address: 2137 Polar Wind Ct. Apt C, Eielson AK
Telephone: 907-372-2730

Senate Bill - 245 Date: 31 JAN 08

Senator Bettye Davis

Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Shannon EPPS
Signature: [signature]
Address: PoB 55924 North Pole AK 99705
Telephone: 907 490-6617

Senate Bill - 245 **Date:** Feb 01, 08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: David W. Rodurtz
Signature: [signature]
Address: 2297 Old Richardson N.P., AK 99705
Telephone: 907-488-4673

Senate Bill - 245 **Date:** 1/31/08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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.

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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 as imposed on the health care in Alaska.

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Jason Elliott
Signature:
Address: 1450 Nymph ct unit B
Telephone: 907 488-1000

Senate Bill - 245 Date: 1-31-08

Senator Bettve Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's 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.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Jessica Eggleston
Signature: Jessica Eggleston
Address: [redacted] Eielson AFB
Telephone: 907 372 2785

Senate Bill - 245 Date: 1-31-08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Mike Hale
Signature: Mike Hale
Address: 706 Dutton Trl. Eagle, AK
Telephone: 907-479-3874

Don Burrell

From: Bonnie Nelson [b.nelson@alaska.com]
Sent: Friday, January 25, 2008 3:49 PM
To: Sen. Bettye Davis
Cc: Thomas Obermeyer
Subject: Please consider an amendment to SB 245

RECEIVED
JAN 28 2008

Senator Davis,
Please consider an amendment to SB 245 that gives the Commission more teeth in establishing a process similar to AGIA for Health Care for ALL, with the same kind of intent that was defined by Governor Palin which was to get the best deal for all Alaskans. Thank you for this consideration.
Bonnie Nelson

23 **Sec. 18.09.070. Duties of the commission.** (a) The commission shall serve as
24 the state health planning and coordinating a process for the implementation of the health care industry's provision of services and goods to ALL Alaskans, including the coordination of cost compilations and analyses and regulations to assure consumer protection so as to include quality and equality of health care for all alaskans.

Don Burrell

From: Doris Robbins [drobbins@gci.net]

Sent: Friday, January 25, 2008 6:56 PM

To: Sen. Fred Dyson; Sen. John Cowdery; Sen. Joe Thomas; Sen. Bettye Davis; Sen. Kim Elton

Cc: Doris Robbins

Subject: *****SPAM***** Re: SB 245 HEALTH CARE: PLAN/COMMISSION/FACILITIES

RECEIVED
JAN 28 2008

After today's hearing on SB 245

Senators,

I did not realize the focus would be 90% on CON today, but I feel I need to follow-up my comments on that. I do think there needs to be some protection for the medical facilities that are taking in so many uninsured. However, there is a problem with them having carte banc control. When there are not physicians enough to treat those who need care it forces an overload onto the other ones who do provide care. Some are leaving Fairbanks and not being replaced. Some are retiring a little early to avoid the Medicare nightmare. One physician listed as being a Medicare provider, when I called "his office" to confirm had retired. I reached him at his home and he provided some insight to our situation here. I learned really fast that just because a doctor is on the Medicare list as a currently available physician doesn't mean it is true. Most are still serving their longtime patients but take on few new patients and generally only take a new patient when they lose one they have.

There are rumors that when Banner Health (now controlling Fairbanks Memorial Hospital) takes over the Tanana Valley Clinic, as is planned, they may become a monopoly that starts behaving like one. Some here think they will close the clinic or use it to whatever purpose serves them best. I have to wonder if they don't presently take advantage of the CON without providing for those who might have been served by a new group. A new physician group could have perhaps come in and shared the patient load, to share the brunt of low Medicare reimbursement. The emphasis seems more on keeping others out than taking care of those other patients. These last things are worries I have heard and not necessarily actual fact.

Only someone like the state can hopefully get on the inside of all the medical facilities and their operations, but from the outside patients see too few physicians available regardless of where they practice. With a chronic asthma condition that at one point before moving here put me in intensive care, I have never been able to see a "chest medicine" physician at the local physician's clinic. I was finally able to be seen by a PA there after calling up with some obvious respiratory distress. I had been told earlier that there were no openings. I think I was seen for fear of some repercussions if I suffered too much trouble from my condition. That was 2004, and there is still only one physician available when a PA can not handle those in trouble and the shortage has only gotten worse. (This is the one and only Fairbanks clinic qualified for serious respiratory conditions.)

When I decided to move up from Juneau to be near my family (grandkids especially) I had been assured that Fairbanks had any kind of medical care that I might need. I suppose that is the message being put out. Moreover, I was a few years away from Medicare in 2004 when I first came here, but Medicare becomes an added factor for me in March 2008. I think the low Medicare reimbursement rate is a lot of the problem.

I saw my designated family physician here two or three times, and any other time it has been the ANP that I saw. The physician who agreed to serve as my family physician is the oncologist who treated me for breast cancer.

I am grateful for the well trained ANP's and PA's, don't misunderstand. I am fine much of the time with seeing them instead of a physician. When I become 65 I'm not sure if I can count on my current physician who is getting closer to retirement himself. I fear there is some serious trouble ahead and some conditions may be missed for some without an occasional doctor doing the checking.

Thanks for your efforts!

Doris Robbins

1281 Overhill Drive
Fairbanks AK 99709
907-374-0597

Below is a copy of my original statement:

> ----- Original Message -----
> **From:** Doris Robbins
> **To:** Senator Joe Thomas ; Senator_Bettye_Davis@legis.state.ak.us
> **Cc:** drobbins@gci.net
> **Sent:** Friday, January 25, 2008 3:59 AM
> **Subject:** RE: SB 245 HEALTH CARE: PLAN/COMMISSION/FACILITIES
>
> Senator Davis,
> Senator Thomas,
> Senate HESS Committee,
>
> RE: SB 245
>
> While I get off on the Medicare problem, that is not the only issue with lack of medical care availability in Alaska, particularly Fairbanks and other farther out communities. While it has been proven that prevention saves dollars for insurance and lives of the insured, prevention is not a common practice. Alaska can reap savings at all angles by employing preventive medicine. Preventive medicine calls the patient to task when they know they will have upfront and personal attention focused on their bad habits! Treating early avoids more costly procedures later.
>
> As someone approaching 65, a member of the Fairbanks community, involved with my peers and hearing their stories of being turned away from their former physicians at reaching age 65, I am fully aware of our urgent need for improvement in the area of health care.
> Many have no choice (PERS/TRS and many other retirees) but to use a physician who accepts Medicare or pay cash out of pocket to visit a physician, with little opportunity for their now secondary insurance to reimburse.
>
> I suppose those with no insurance have a much more difficult time, but I have one senior friend (couple) that both have a potentially life threatening skin cancer and lost their dermatologist although they had been fully insured under AlaskaCare, the state's retiree insurance plan which is touted as the ultimate insurance plan.
>
> Many seniors have some access to physicians when they have a long treatment history with their physician. It is pretty scary when you are now elderly and your need for competent care has grown and a physician you had a relationship with fires you. So where do you go then? Do you expect a physician with whom you have no prior relationship to now take you as a patient? (I can still hear the laughter!) Some bite the bullet, they tell me, and begin paying extra upfront "for as long" as they can manage the costs. Most do not have the ability to do that.
>
> Some have told me they received a formal letter that told them that if they would pay a $300 retainer fee, they could continue to be seen. I thought this was against the law but learned that all a physician has to do to dump a patient is to mail them an official letter saying they no longer accept patients with Medicare.

I don't blame the physicians! Between going broke from treating Medicare patients for "next to nothing" and dealing with a fouled up system that is slower than slow, they just can't take it!!

From my own recent experience of trying to "do everything just right" when signing up for Medicare, I can empathize! Beginning March 2008 I'll learn all about what Medicare offers Alaskans.

I did a survey of Fairbanks physicians who were accepting newly-turned-65 patients last year. Most said they would keep patients they already had. However, some physicians had flat retired out of being to stressed out with the paper work, or fear of going broke. I've learned from physicians' staff that for other potential patients there are long waiting lists. To be seen, a current patient has to leave or die, and you make an appointment before the slot fills. New physicians are not filling empty physician slots because the word has gotten around how bad it is here. Some just graduated physicians are coming here to get a start and sometimes with a monetary incentive to do so.

I got the names of new physicians (who would take Medicare until their practice filled) from one clinic, told my friends who were looking, and before they could call the physicians were booked solid with their Medicare quota. In addition, Fairbanks has a large military population which qualify for lower payment options. We were already short enough physicians to go around before the military build-up. We love our military families, though, and want them to have the best as well.

Something has to be done! I hope that by "state heads being put together" some solutions can be found. We are at a crisis situation even before having any crisis. I am pleased to see that there are many from various backgrounds and political affiliations willing to get together to search for solutions.

Sincerely,

Doris Robbins

drobbins@gci.net

1281 Overhill Drive
Fairbanks AK 99709
(907) 374-0597

No virus found in this incoming message.
Checked by AVG Free Edition.
Version: 7.5.516 / Virus Database: 269.19.10/1241 - Release Date: 1/24/2008 9:58 AM



Health Program

Certificate of Need: State Health Laws and Programs

December 1, 2006 - preliminary edition

Certificate of Need (C.O.N.) programs are aimed at restraining health care facility costs and to allow coordinated planning of new services and construction. Laws authorizing such programs are one mechanism by which state governments seek to reduce overall health and medical costs. Many "CON" laws were put into effect across the nation as part of the federal "Health Planning Resources Development Act" of 1974. Despite numerous changes in the past 30 years, about 36 states retain some type of CON program, law or agency as of mid-2006.

TABLE OF CONTENTS

- Pro and Con views
- CON Programs
- Regulated services
- CON legislation, 05-06
- Resources & reports

HISTORY



In 1964, New York became the first state to enacted a statute granting the state government power to determine whether there was a need for any new hospital or nursing home before it was approved for construction. Four years later the American Hospital Association expressed an interest in Certificate of Need laws. The AHA started a national campaign for states to generate their own CON laws. By 1975, 20 states had enacted CON laws; by 1978, 36 states had enacted them.

The 1974 federal Act required all 50 states to submit proposals and obtain approval from a state health planning agency before beginning any major capital projects such as building expansions or ordering new high-tech devices. Many states implemented CON programs in part because of the incentive of federal funds.

The federal mandate was repealed in 1987, along with its federal funding. In the decade that followed, 14 states discontinued their CON programs.However, 36 states currently maintain some form of CON program, and even the 14 that repealed their state CON laws still retain some mechanisms intended to regulate costs and duplication of services. Puerto Rico and the District of Columbia also have CON programs.

States that have retained CON programs currently tend to concentrate activities on outpatient facilities and long-term care. This is largely due to the trend toward free-standing, physician owned facilities that constitute an increasing segment of the health-care market.

INTENT

The basic assumption underlying CON regulation is that excess capacity (in the form of facility overbuilding) directly results in health care price inflation. When a hospital cannot fill its beds, fixed costs must be met through higher charges for the beds that are used. Bigger institutions have bigger costs, so CON supporters say it makes sense to limit facilities to building only enough capacity to meet actual needs.

CON programs originated to regulate the number of beds in hospitals and nursing homes, and to prevent overbuying of expensive equipment. Mandatory regulation through health planning agencies determined the most urgent health care needs, contributed to solutions for these needs, and attempted to manage the fluctuations in prices often caused by a competitive market. The idea was that new or improved facilities or equipment would be approved based only on a genuine need in a community. Statutory criteria often were created to help planning agencies decide what was necessary for a given location. By reviewing the activities and resources of hospitals, the agencies made judgments about what needed to be improved. Once need was established, the applicant organization (corporation, not-for-profit, partnership or public entity) was granted permission to begin a project. These approvals were known as "Certificates of Need."

C.O.N. SUPPORTERS' VIEWS	C.O.N. OPPONENTS' VIEWS
Advocates of CON programs say that health care cannot be considered as a "typical" economic product. They argue that many "market forces" do not obey the same rules for	CON programs also have been subject to wide criticism. To start, it is not clear that these state-sponsored programs actually controlled health care costs. For example, by restricting new construction, CON

health care services as they do for other products. In support of this argument, it is often pointed out that, since most health services (like an x-ray) are "ordered" for patients by physicians, patients do not "shop" for these services the way they do for other commodities. This makes hospital, lab and other services insensitive to market effects on price, and suggests a regulatory approach based on public interest.

The American Health Planning Association (AHPA) is the professional group of state agencies responsible for regulation and planning. They identify three factors that suggest the need for CON programs. The primary argument is that CON programs limit health-care spending. CONs can promote appropriate competition while maintaining lower costs for treatment services. The AHPA argues that by controlling construction and purchasing, state governments can oversee what expenditures are necessary and where funds will be used most effectively. This helps eliminate projects that detract attention from more urgent and useful investments and reduces excessive costs. AHPA also asserts that CONs have a valuable impact on the quality of care. When facilities and equipment are monitored, hospitals and other treatment centers can acknowledge what sort of services are in demand and how effectively patients are being taken care of. Additionally, according to supporters, the programs distribute care to areas that could be ignored by new medical centers. CON programs are a resource for policymakers. CON regulations are described as a reliable way to implement basic planning policies and practices, and aid in distributing health care to all demographic areas. The CON process can call attention to areas in need because planners can track and evaluate the requests of hospitals, doctors and citizens and see which areas are underserved or need to be improved and developed.

programs may reduce price competition between facilities, and may actually keep prices high. Barriers to new building were seen as unfair restrictions, sometimes by both existing facilities and their potential new competitors. There is little direct broad proof that overcapacity or duplication leads to higher charges. In 2004 the Federal Trade Commission (FTC) and the Department of Justice both claimed that CON programs actually *contribute* to rising prices because they inhibit competitive markets that should be able to control the costs of care and guarantee quality and access to treatment and services. (*1*)

Some opponents felt that changes in the Medicare payment system (such as paying hospitals according to Diagnostic Related Groups - "DRGs") would make external regulatory controls unnecessary, because health care organizations would be more subject to market pressures. Some pointed out that the CON programs are not consistently administered. A 'flexible' program could allow development, to the dismay of competitors. A 'restrictive' program could limit competition, with the same effect. Many argued that health 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.

Some evidence suggests that lack of competition paradoxically *encouraged* construction and additional spending. Some opponents of CON programs believe an open health care market, based on quality rather than price, might be the best principle for containing rising costs. Proponents of CON programs disagree. This debate rests on the same arguments as many other "Regulated market" vs. "Open market" discussions.

In theory, Certificates of Need are granted based on objective analysis of community need, rather than the economic self-interest of any single facility. However, opponents of CON programs claim that the programs have not worked this way. They cite examples in which CONs were apparently granted on the basis of political influence, institutional prestige or other factors apart from the interests of the community. Furthermore, it is sometimes a matter of debate what sort of development is actually in the community's interest, with people of good will sharply divided on how to determine this.

Other Approaches

Many approaches have been tried to controlling health care costs, including government and industry regulation, provider incentives, "free market" incentives and educational efforts. Some of these include:

1. Limitations on physician referrals to facilities in which they or a family member have a financial interest (so-called "Stark regulations").
2. Supervision by insurers to make sure a treatment request is necessary (precertification, concurrent or retrospective medical necessity review).
3. Prepayment for insured or covered services ("managed care")
4. Fixed payments for defined services ("Information Individual Programs DRGs"- uniform Diagnostic-Related Groups)
5. Providing information to patients about the costs and necessity of certain tests and treatment (includes "transparency" and disclosure programs)
6. Providing information to patients about the quality of and outcomes at certain medical facilities.

Footnotes:

1. The Federal Trade Commission, Department of Justice, *Improving Health Care: A Dose of Competition* (Washington D.C.: FTC, DOJ, 2004) 361 pages ~ PDF.

STATES WITH CON PROGRAMS



Compiled by NCSL, based on data from AHPA, June 2006

State/District with CON Programs	Dates of Programs	Certificate of Need Contact Information	Individual CON Websites
Alabama	1977-present	**James E. Sanders**, Deputy Director Phone: 334-242-4103; Fax: 334-242-4113 james.standers@shpda.alabama.gov	http://www.shpda.state.al.us
Alaska	1976-present	**David Pierce**, CON Coordinator Phone: 907-465-3001; Fax: 907-465-4101 david_pierce@health.state.ak.us	Alaska's Certificate of Need Program
Arizona	1971-1985		**No CON Program; see planning agency below**
Arkansas	1975-present	**Deborah Frazier**, Director Phone: 501-661-2509; Fax:501-661-2399 dfrazier@healthyarkansas.com	http://www.arhspa.org
California	1969-1987		**No CON Program; see planning agency below**
Colorado	1973-1987		**No CON Program; see planning agency below**
Connecticut	1973-present	**Susan Cole**, Director Phone: 860-418-7038; Fax: 860-418-7053 susan.coleengland@po.state.ct.us	Connecticut's Certificate of Need Program
Delaware	1978-present	**Francis Osei-Afriyie**, Management Analyst Phone: 302-741-2960; Fax: 302-741-2970 francis.osei-afriyie@state.de.us	Delaware's Certificate of Public Review Program
District of Columbia	1968-present	**Amaha Selassie**, Chief, Project Review Phone: 202-442-5875; Fax: 202-442-4824	DC Certificate of Need Website
Florida	1972-present	**Jeff Gregg**, Bureau Chief Phone: 850-922-8672; Fax: 850-488-6964 greggj@fdhc.state.fl.us	Florida Licensing and Certification
Georgia	1979-present	**Robert Rozier**, Esq., Executive Director Phone: 404-657-7198; Fax: 404-656-0554 rrozier@dch.ga.gov	Georgia's Certificate of Need Program
Hawaii	1974-present	**David Sakamoto**, MD, Administrator Phone: 808-587-0788; Fax: 808-587-0783 david@shpda.org	Hawaii's website for Certificate of Need
Idaho	1980-1983		**No CON Program; see planning agency below**
Illinois	1974-present	**Jeffrey Mark**, Health Planning Board Phone: 217-783-3516; Fax: 217-785-4308	http://www.idph.state.il.us/about/hfpb.htm

		jmark@idph.state.il.us	
Indiana	1980-1996, 1997-1999		No CON Program; see planning agency below
Iowa	1977-present	**Barb Nervig**, Program Manager Phone: 515-281-4344; Fax: 515-281-4958 bnervig@idph.state.ia.us	http://www.idph.state.ia.us/do/cert_of_need.asp
Kansas	1972-1985		No CON Program; see planning agency below
Kentucky	1972-present	**Chris Corbin**, Executive Director Phone: 502-564-9589; Fax: 502-564-0302	http://chfs.ky.gov/ohc/con
Louisiana	1991-present	**James Taylor**, Program Manager Phone: 225-342-3881; Fax: 225-342-3893 jntaylor@hhh.la.gov	http://www.dhh.state.la.us/
Maine	1978-present	**Catherine Cobb**, Director Phone: 207-287-2979; Fax: 207-287-5282 catherine.cobb@maine.gov	Maine Certificate of Need Procedures Manual Maine Government Website
Maryland	1968-present	**Paul Parker**, Acting Chief Phone: 410-764-3261; Fax: 410-358-1311 pparker@mhcc.state.md.us	Maryland Certificate of Need Program
Massachusetts	1972-present	**Joan Gorga**, Acting Director Phone: 617-753-7340; Fax: 617-753-7349 Joan.Gorga@state.ma.us	http://www.state.ma.us/dph/dhcq/don.htm
Michigan	1972-present	**Larry Horvath**, Manager Phone: 517-241-3343; Fax: 517-241-2962 horvathl@michigan.gov	http://www.michigan.gov/con
Minnesota	1971-1985		No CON Program; see planning agency below
Mississippi	1979-present	**Rachel Pittman**, Chief, P&RD Phone: 601-576-7874; Fax: 601-576-7530 rachel.pittman@msdh.state.ms.us	Mississippi Certificate of Need Program
Missouri	1979-present	**Thomas Piper**, Director Phone: 5573-751-6043; Fax: 573-751-7894 tpiper@mail.state.mo.us	www.dhss.mo.gov/con
Montana	1975-present	**Pamela Sourbeer**, Administrative Officer Phone: 406-444-9519; Fax: 406-444-1742 psourbeer@mt.gov	Administrative Rules of Montana CON
Nebraska	1979-present	**Claire Titus**, Section Program Manager Phone: 402-471-4963; Fax: 402-471-3577 claire.titus@hhss.ne.gov	http://www.hhs.state.ne.us/crl/need.htm
Nevada	1971-present	**Lynn Solano**, RN, Health Resource Analyst Phone: 775-684-4177; Fax: 775-684-4156 lsolano@nvdh.state.nv.us	http://www.health2k.state.nv.us/vs/letter.htm
New Hampshire	1979-present	**Margaret Heatley**, Administrator Phone: 603-271-4606; Fax: 603-271-4141 m.heatley@dhhs.state.nh.us	http://www.nhha.org/nhha/state_law/con.php
New Jersey	1971-present	**John Calabria**, Director Phone: 609-292-8773; Fax: 609-292-3780 john.calabria@doh.state.nj.us	(none) http://www.state.nj.us/health/forms/cn-Z_7a.pdf (application only)
New Mexico	1978-1983		No CON Program; see planning agency below
New York	1966-present	**Christopher Delker**, Program Research Sp. Phone: 518-402-0966; Fax: 518-402-0971 crd02@health.state.ny.us	http://www.health.state.ny.us/nysdoh/cons/index.htm
North Carolina	1978-present	**Lee Hoffman**, Chief Phone: 919-855-3873; Fax: 919-733-8139 Lee.Hoffman@ncmail.net	http://facility-services.state.nc.us/
North Dakota	1971-1995		No CON Program
Ohio	1975-present	**Christine Kenney**, CON Director Phone:	Ohio CON webpage

		614-644-3325; Fax: 614-752-4157 christine.kenney@odh.ohio.gov	
Oklahoma	1971-present	**Darlene Simmons**, Director Phone: 405-271-9444; Fax: 405-271-7360 darlen@health.state.ok.gov	Oklahoma CON Abstract
Oregon	1971-present	**Jana Fussell**, CON Coordinator Phone: 503-731-4320; Fax: 503-731-4078 jana.fussell@state.or.us	Oregon CON Webpage
Pennsylvania	1979-1996		No CON Program; see planning agency below
Puerto Rico	1975-present		Consultant CON webpage
Rhode Island	1968-present	**Michael K. Dexter**, Chief, Office of Health Systems Development Phone: 410-222-2788; Fax: 410-273-4350 michael.dexter@health.ri.gov	http://www.health.ri.gov/hsr/healthsystems/index.php
South Carolina	1971-present	**Joel C. Grice**, Director Phone: 803-545-4200; Fax: 803-545-4570 gricejc@dhec.sc.gov	http://www.scdhec.gov/hr/cofn/
South Dakota	1972-1988		No CON Program; see planning agency below
Tennessee	1973-present	**Melane M. Hill**, Executive Director Phone: 615-741-2364; Fax: 615-741-9884 melanie.hill@state.tn.us	http://tennessee.gov/hsda/cert_need_sum.html
Texas	1975-1985		No CON Program; see planning agency below
Utah	1979-1984		No CON Program; see planning agency below
Vermont	1979-present	**Jennifer Garson**, CON Analyst Phone: 802-828-2900; Fax: 802-828-2949 jgarson@bishca.state.vt.us	Vermont CON program
Virginia	1973-present	**Erik Bodin**, Director Phone: 804-367-2126; Fax: 804-367-2206 Erik.Bodin@vdh.virginia.gov	http://www.cvhpa.org/COPN.htm
Washington	1971-present	**Janis Sigman**, Manager Phone: 360-236-2956; Fax: 360-236-2901 janis.sigman@doh.wa.gov	Washington CON program
West Virginia	1977-present	**Dayle CON PlanningStepp**, CON Director Phone: 304-558-7000; Fax: 304-559-7001 dstepp@hcawv.org	http://www.hcawv.org/CertOfNeed/conHome.htm
Wisconsin	1977-1978, 1993-present	**C. David Lund**, Chief, N.H. Section Phone: 608-266-2021; Fax: 608-264-7720 lundcd@dhfs.state.wi.us	Wisconsin Resource Allocation Program
Wyoming	1977-1989		No CON Program; see planning agency below

HEALTH PLANNING AGENCIES IN STATES WITHOUT CURRENT C.O.N. PROGRAMS

State	Dates of CON law	Planning Agency & Contacts	
Arizona	1971-1985	**Patricia Taranga**, Chief Phone: 602-542-1219; Fax: 602-542-2011 ptargan@hs.state.az.us	No CON Program
California	1969-1987	**Jonathan M. Teague**, Manager Phone: 916-322-2814; Fax: 916-324-9242 jteague@oshpd.state.ca.us	No CON Program
Colorado	1973-1987	**Susan Rehak**, Contact Phone: 303-692-2470; Fax: 303-782-5576 susan.rehak@state.co.us	No CON Program
Idaho	1980-1983	**Jane Smith**, Chief Phone: 208-334-5976; Fax: 208-332-7360 smithj2@idhw.state.id.us	No CON Program
Indiana	1980-1996, 1997-	**Tom Reed**, Public Health Administrator Phone:	No CON Program

	1999	317-233-7541; Fax: 317-233-7157 treed@isdh.state.in.us	
Kansas	1972-1985	**Richard J. Morrissey**, Interim Director Phone: 785-296-1343; Fax: 785-296-1562 rmorriss@kdhe.state.ks.us	No CON Program
Minnesota	1971-1985	**Sheila Brunelle**, Principal Planner Phone: 651-282-3853; Fax: 651-297-5808 sheila.brunelle@health.state.mn.us	No CON Program
New Mexico	1978-1983	**Karen Meader**, Deputy Director Phone: 505-424-3200; Fax: 505-424-3222 kmeader@hpc.state.nm.us	No CON Program
North Dakota	1971-1995	**Gary Garland**, Contact Phone: 701-328-2894; Fax: 701-328-1890 ggarland@state.nk.us	No CON Program
Pensylvania	1979-1996	**Michelle S. Davis**, Deputy Secretary Phone: 717-783-8804; Fax: 717-772-6959 msdavis@state.pa.us	No CON Program
South Dakota	1972-1988	**Doneen Hollingsworth**, Secretary Phone: 605-773-3361; Fax: 605-773-5683 doneen.hollinsgworth@state.sd.us	No CON Program
Texas	1975-1985	**Connie Turney**, Project Director Phone: 512-458-7261; Fax: 512-458-7344 connie.turney@dshs.state.tn.us	No CON Program
Utah	1979-1984	**Scott Williams**, MD, MPH, Executive Director Phone: 801-538-6111 sdwilliams@utah.gov	No CON Program
Wyoming	1977-1989	**Morris Gardner**, Senior Advisor Phone: 307-777-7656; Fax: 307-777-7439 mgardn@state.wy.us	No CON Program

Contact information obtained from American Health Planning Association National Directory, 2006 edition.

FACILITIES AND SERVICES REGULATED BY C.O.N.

Regulated Services	States, with Districts & Commonwealth
Acute Hospital Beds	AL, AK, CT, DE, FL, GA, HI, IL, KY, ME, MD, MI, MS, MO, NV, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC, PR
Air Ambulance	AK, CT, HI, ME, MA, MI, NC, TN, VT
Ambulatory Surgical Centers	AL, AK, CT, DE, GA, HI, IL, IA, KY, ME, MD, MA, MI, MS, MT, NV, NH, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC, PR
Assisted Living *(also see Residential Care, below)*	AK
Behavioral Health	WV
Birthing Centers	DE
Burn Care	AK, CT, FL, HI, IL, ME, MD, NJ, NY, NC, VT, WA, WV
Business Computers	CT, VT, WV
Cardiac Catheterization	AL, AK, CT, DE, GA, HI, IL, IA, KY, ME, MD, MI, MS, MO, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC
Computed Tomography (CT) Scanners	AK, CT, GA, HI, ME, MI, MO, NH, NY, NC, RI, TN, VT, VA, DC, PR
Gamma Knives	AL, AK, CT, GA, HI, IL, ME, MA, MI, MS, MO, NY, NC, RI, SC, VT, VA, WV, DC.
Home Health	AL, AK, AR, GA, HI, KY, MD, MS, MT, NJ, NY, NC, SC, TN, VT, WA, WV, DC
Hospice	AL, AK, AR, CT, FL, IL, KY, MD, MS, NV, NY, NC, OH, TN, VT, WA, WV, PR
Hospital *(also see Acute Hospital, above)*	MI, MO
Intensive Care	NC

Intermediate Care Facilities/Mental Retardation (ICF/MR)	AR, FL, GA, HI, IL, IA, KY, LA, ME, MD, MS, MO, MT, NV, NJ, NY, NC, OK, SC, TN, VT, VA, WV, WI, PR
Long Term Acute Care (LTAC)	AL, AK, CT, DE, FL, GA, HI, IL, KT, ME, MD, MA, MI, MS, MO, NV, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC, PR
Lithotripsy	AL, AK, CT, DE, GA, HI, KY, ME, MA, MI, MS, MO, NH, NY, NC, SC, TN, VT, VA, WV, DC.
Long Term Care	AL, AK, AR, CT, DE, FL, GA, HI, IL, IA, KY, LA, ME, MD, MA, MI, MS, MO, MT, NE, NH, NV, NJ, NY, NC, OH, OK, OR, RI, SC, TN, VT, VA, WA, WV, WI, DC, PR
Medical Office Buildings	CT, GA, DC
Medical Services for Indigents (MSI)	VA
Mobile HI Technology (CT / MRI / PET, etc)	AK, CT, GA, HI, KY, ME, MI, MO, NH, NY, NC, RI, SC, VT, VA, WV, DC
Mobile Medical Services	KY
Magnetic Resonance Imaging (MRI) Scanners	AL, AK, CT, GA, HI, KY, ME, MA, MI, MS, MO, NH, NY, NC, RI, SC, TN, VT, VA, WV, DC
Neo-Natal Intensive Care	AL, AK, CT, FL, GA, HI, IL, KY, ME, MD, MA, MI, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC
Obstetrics Services	AL, AK, CT, GA, HI, IL, ME, MD, NY, RI, SC, VT, VA, WA, WV, DC
Open Heart Services	AL, AK, CT, FL, GA, HI, IL, IA, KY, ME, MD, MA, MI, MS, MO, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC
Organ Transplants	AL, AK, CT, FL, GA, HI, IL, IA, KY, ME, MD, MA, MI, MO, NJ, NY, NC, RI, VT, VA, WA, WV, DC
Positron Emission Tomography (PET) Scanners	AL, AK, CT, DE, GA, HI, IL, IA, ME, MA, MI, MS, MO, NH, NY, NC, RI, SC, TN, VT, VA, WV, DC, PR
Psychiatric Services	AL, AK, CT, FL, GA, HI, IL, KY, ME, MD, MA, MI, MS, NH, NJ, NY, NC, OK, RI, SC, TN, VT, VA, WV, DC, PR
Radiation Therapy	AL, AK, CT, DE, GA, HI, IL, IA, KY, ME, MD, MA, MI, MS, MO, NH, NY, NC, RI, SC, TN, VT, VA, WV, DC
Rehabilitation	AL, AK, CT, GA, HI, IL, KY, ME, MD, MA, MS, MT, NE, NV, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC
Renal Failure/Dialysis	AL, AK, HI, IL, ME, MS, MO, NY, NC, VT, WA, WV, DC
Assisted Living & Residential Care Facilities	AK, AR, CT, GA, KY, MA, MS, MO, NJ, NY, NC, WV
Single Photon Emission Computed Tomography (SPECT)	VA
Subacute Services	AK, AR, FL, GA, HI, IL, KY, MD, NV, OK, RI, SC, TN, WA, WI, DC
Substance/Drug Abuse	AL, AK, CT, FL, GA, HI, ME, MD, MA, MS, MT, NV, NH, NY, NC, OK, RI, SC, TN, VT, VA, WV, DC
Surgery *(also see Amulatory Surgical Centers)*	MI
Swing Beds	AL, AK, AR, CT, GA, HI, IL, ME, MI, MS, MT, NY, NC, OR, RI, TN, VT, WA, WV, DC
Ultra-Sound	AK, CT, ME, MO, NY
Other (Not otherwise covered)	AL, AR, CT, GA, IL, KY, MD, MA, MI, NC, OK, TN, WA, WI, PR

***NOTE*: The categories listed above are for general information. See state-specific limitations, exceptions and requirements.**

CON Online Sources & Resources:

1. http://www.ahpanet.org/articlescopn.html **Articles and essays collected from American Health Planning Association**

2. http://www.washingtonpolicy.org/HealthCare/PBBARNESCON.htm **Opponent view of CON Program using Washington State as example.**

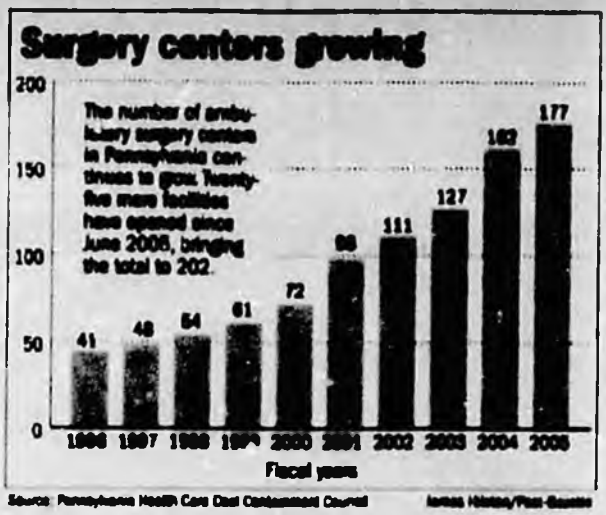
3. www.ftc.gov **The Federal Trade Commission website**

4. http://www.ahpanet.org/websites_copn.html **American Health and Planning Association with other planning related websites and a list of websites for the CON programs of each state.**

http://www.ahpanet.org/index.html

5. http://content.healthaffairs.org/cgi/reprint/hlthaff.25.w337v1

6. http://rs6.net/tn.jsp?t=hxgahxbab.0.r8qvn8n6.uqoukvn6.124901&p=http%3A%2F%2Fwww.healthaffairs.org



7. 'Monopoly is not the Answer' an abstract of how regulations have affected the markets. ***Health Affairs,*** August 9, 2005.

8. 'Effects of Physician-Owned Limited Service Hospitals: Evidence from Arizona' an abstract. ***Health Affairs,*** October 25, 2005.

9. 'Political Evolution of Federal Health Care Regulation' ***Health Affairs,*** Copyright 1992.

10. 'Specialty Versus Community Hospitals: What Role for the Law?' ***Health Affairs,*** August 9, 2005.

11. 'Rules of the Game: How Public Policy affects local Health Care Markets' ***Health Affairs,*** Copyright 1998.

12. http://www.law.fsu.edu/journals/lawreview/issues/231/heading2

2005-06 Examples of CON State Legislation

State/Bill/Web link/Sponsor *yellow background=enacted*	Descriptions of Bills/Excerpts of bill text
AK HB 287 Rep. Lynn	An act a...ending the certificate of need requirements to apply only to health care facilities and nursing homes located in borough with a population of not more than 25,000, in the unorganized borough, or in a community with a critical access hospital. *(Filed 4/27/05; did not pass by end of regular session, 2006)*
CA SB 666 Sen. Aanestad	An act to amend Section 1250 of the Health and Safety Code, relating to health facilities. *(Filed 2/22/05; passed House 66y-4n, 9/8/05; passed Senate 44y-1n, 9/8/05; signed into law by Governor as Chapter 443, 9/30/05)*
CT HB 5242 Rep. Dillon	An examination of the State's current and future hospital bed capacity and hospital-based graduate medical education. *(Filed 2/16/06; did not pass by end of regular session, 2006)*
CT HB 5468 Public Hlth. Comm.	To increase the certificate of need threshold for all capital expenditures, including major medical equipment, to three million dollars. *(Filed 2/22/06; passed House 142y-0n 4/11/2006; passed Senate 35y-0n 4/21/06; signed into law by Governor 5/8/06)*
CT HB 5719 Public Hlth. Comm.	To make the certificate of need process for new or expanded emergency medical services clearer and more consistent. *(Filed 3/3/06; did not pass by end of regular session, 2006)*
CT SB 309 Public Hlth. Comm.	To allow certified or licensed emergency medical service providers to add one emergency vehicle to their service every three years without undergoing a needs assessment by the Office of Emergency Medical Services, to clarify the Commissioner of Public Health's responsibilities with respect to establishing methods for setting emergency service rates for certified ambulance services and to protect patients from the dangers of secondhand smoke while being transported to or from nonemergency medical services. *(Filed 2/22/06; did not pass by end of regular session, 2006)*
CT	To revise statutes pertaining to the Office of Health Care Access.

SB 386 Public Needelman WouldHlth. Comm.	*(Filed 2/23/06; passed Senate 33y-0n 4/20/06; passed House 146y-0n 4/28/06; signed into law by Governor 5/19/06)*
CT SB 621 Public Hlth. Comm.	To require the Department of Health to establish a standard set of exemptions for single specialty outpatient surgical facilities from licensure and certificate of need requirements. *(Filed 3/8/06; did not bass by end of regular session, 2006)*
FL HB 1565 Rep. Needelman	Would require county commissioners board to issue certificate of public convenience & necessity to any municipality that applies for such certificate to provide advanced life support transport or nontransport emergency medical services within its geographic limits or outside its geographic limits by mutual agreement with governing body of jurisdiction served, etc. *(Filed 3/8/05; died in committee 5/6/05)*
FL HB 1829	For Holmes County Hospital Corporation, amends special act and revises provisions regarding corporation's issuance of bonds to construct and erect new hospital facility in Holmes County; repeals various provisions of said special act. *(Passed House and Senate; signed into law by governor, as Chapter No. 2005-352, 6/13/06)* |
FL HB 7051 Rep. Gibson	Extends moratorium on certificates of need for additional community nursing home beds until July 1, 2011; specifies nonapplication of moratorium for addition of nursing home beds in certain specified facilities; provides for repeal upon expiration of moratorium; exempts nursing home that is created by combining certain licensed beds from requirements for obtaining certificate of need from AHCA, etc. *(Filed 2/22/06; passed House 120y-0n 4/19/06; passed Senate 34y-0n 4/20/06; signed into law by Governor 6/9/2006)*
FL HB 7141 Rep. Garcia	Requires healthcare providers to display licenses; exempts nursing home created by combining certain licensed beds from requirements for obtaining certificate of need from AHCA; establishes trauma center startup grant program, etc. *(Filed 3/17/2006; passed House 114y-0n, 4/28/06; passed Senate 40y-0n, 5/4/06; signed into law by Governor 6/12/06)*
FL SB 1516 Sen. Wilson	Would create intergenerational respite care assisted living facility pilot program; provides duties of AHCA re program; provides requirements & standards for program; provides for rules; requires report to Legislature. *(Filed 2/15/05; did not pass by end of regular session, 2006)*
FL SB 2158 Sen.	Would amend provision re health-care-related projects subject to review for certificate of need; exempts class II specialty hospitals specializing in delivery of health services to pediatric patients from requirement to obtain certificate of need from AHCA; provides criteria for such exemption. *(Filed 2/16/06; died in committee 3/22/06; did not pass by end of regular session)*
GA HB 390 Rep. Scott	State Commission on the Efficacy of the Certificate of Need Program *(Filed 2/9/05; passed House 151y-0n 3/3/05; passed Senate 42y-0n, 3/22/05; signed into law by Governor 4/7/05)*
GA SB 242 Sen. Hudgens	Relates to the certificate of need program, so as to provide for an exemption from the certificate of need requirements for the voluntarily relocation of a health care facility under certain conditions; to provide for an exemption from the certificate of need requirements for the relocation, repair, or replacement of a health care facility that is damaged, destroyed, or rendered inoperable under certain conditions; to provide for related matters; to provide for an effective date; to repeal conflicting laws; and for other purposes. (Filed 2/23/05; did not pass by end of regular session, 2005)
HI HB 137 Rep. Evans	Exempts all long-term care facilities at all levels of care from the certificate of need process under the state health planning and development agency. *(Filed 1/20/2005; carried over to 2006 session 12/2/05)*
IL SB 569 Sen. Garrett	Amends the Illinois Health Facilities Planning Act. Provides that "capital expenditure minimum" means $10,000,000 (now, 6,000,000) and "non-clinical service area" includes research facilities, auditoriums, and medical office buildings. Provides that permits are not required for the establishment of swing-beds authorized under Title XVIII of the federal Social Security Act, or for the modification of a hospital's bed capacity. Provides that the Illinois Health Facilities Planning Act is repealed on July 1, 2011 (now July 1, 2006). Effective immediately. *(Filed 2/17/05; passed Senate 56y-0n 4/14/05; did not pass by end of regular session, 2005)*
IL SB 2436 Sen. Crotty	Amends the Illinois Health Facilities Planning Act. Requires inventories of certain skilled or intermediate care facilities to be conducted annually by July 1, to list services provided, and to differentiate between active and inactive beds. Effective immediately.

	(Filed 1/18/06; passed Senate 57y-0n 3/2/06; passed House 105y-4n 5/4/06; signed into law by Governor 6/30/06)
IN SB 161 Sen. Miller	Moratorium on comprehensive care beds. Imposes a moratorium on the construction or addition of comprehensive care beds through June 30, 2007, with certain exceptions. *(Filed 1/9/06; passed Senate 45y-2n 1/26/06; passed House 88y-0n 3/1/06; signed into law by Governor 3/20/06)*
IA HSB 614 SSB 3072 Chair Upmeyer	An Act relating to placing nursing facility beds in reserve. *(Filed 1/31/06; did not pass by end of regular session, 2006)*
KS HB 2799	Concerns adult care homes, relating to home plus beds. *(Filed 2/1/06; did not pass by end of regular session, 2006)*
KS HR 6036	Would Memorialize the Congress of the United States regarding the benefits of speciality hospitals. *(Filed and sent to committee, 4/29/06; did not pass by end of session, 6/06)*
KS S.R. 1856, SR 1862	Memorializes the U.S. Congress to continue the current federal moratorium on specialty hospitals. *(Filed 4/1/06; SR 1862 passed Senate 4/30/06)* |
KY SB 61 Sen. Kelly	To replace the Office of Certificate of Need with the Office of Health Policy for Health and Family Services. *(Filed 1/6/06; passed Senate 92y-3n, 3/24/06; passed House 4/11/06; signed into law by Governor in Acts Chapter 181, 4/18/06)*
LA HB 1337 Rep. Thompson	To provide for the certificate of rural necessity program. *(Filed 4/18/06; did not pass by end of regular session, 2006)*
LA SB 311 Sen. Hines	Provides for the needs assessment review for the approval of federally qualified healthcare centers. *(Filed 3/17/06; did not pass by end of regular session, 2006)*
LA SB 754 Sen. Cravins	Related to adult day healthcare providers and to provide for related matters. *(Filed 6/1/06; passed House 90y-0n, 6/16/06; passed Senate 32y-0n, 6/16/06; signed into law by Governor as Act 637, 6/23/06)*
ME HB 1254 LD 1814 Rep. Miller	Proposes to amend the certificate of need law to improve review procedures in the certificate of need program within the Department of Health and Human Services. *(Filed 12/28/2005; died in committee 4/26/06)*
ME HB 1315 LD 1875 Rep. Millett	Provides improved services to persons in rehabilitation programs; Directs the Department of Health and Human Services, Office of Substance Abuse to evaluate need when issuing licenses, etc. *(Filed 1/3/06; passed House 3/23/06; passed Senate 3/27/06; signed into law by Governor 3/30/06)*
ME SB 225 LD 688 Sen. Dow	An act to ensure access to swing beds in hospital *(Filed 2/10/05; died in committee 5/23/05)*
ME SB 490 LD 1401 Sen. Brennan	To further coordinate the laws regarding certificate of need, the state health plan and the Capital Investment Fund. *(Filed 3/22/05; passed House 6/8/05; passed Senate 6/8/05; signed into law by Governor 6/10/05)*
ME SB 701/LR 2677 LD 1784 Sen. Rosen	Requires the Department of Health and Human Services to allow construction contingency budgeting for capital projects that is consistent with industry standards in a certificate of need application. *(Filed 12/30/05; passed House 4/10/06; passed Senate 4/10/06; signed into law by Governor 4/13/06)*
ME SB 852 LD 2110 Comm. of HHS	Repeals the Hospital Cooperation Act of 1992; Enacts the Hospital and Health Care Provider Cooperation Act. *(Filed 4/13/06; passed House5/23/06; passed Senate5/23/06; signed into law by Governor 5/30/06)*
MD HB 1015/SB 832 Rep. Pendergrass	Altering the level of capital expenditures made by or on behalf of a hospital or a health care facility other than a hospital that requires a certificate of need, etc. *(Filed 2/9/06; passed House 4/1/06; passed Senate 4/1/06; Governor vetoed 5/26/06)*

MD HB 1105 Rep. Morhaim	Requiring the Maryland Health Care Commission to adopt rules and regulations for certification of need that provide consideration for hospital projects that incorporate the requirements for a high performance building; and requiring the Health Services Cost Review Commission, in the determination of reasonable rates for each facility, to take into account the costs of hospital projects that incorporate the requirements for a high performance building. *(Filed 2/9/06; passed House 3/17/06; did not pass by end of regular session, 2006)*
MD HB 1420/SB 529 Rep. Smigiel	Repealing a specified requirement for a specified State health plan relating to the certificate of need program, etc. *(Filed 2/10/06; did not pass by end of regular session, 2006)*
MA S 1293 Sen. Moore	Determination of need for hospital beds. *(Filed 1/26/05; did not pass by end of regular session, 2005)*
MA S. 1299	Would study the delivery of specialty hospitals. *(Filed 1/5/05; did not pass by end of regular session, 3/20/06)*
MA S 2141 Public Hlth Comm.	Amends law regulating need for hospital beds. *(Filed 6/30/05; did not pass by end of regular session, 2006)*
MA HD 4853 Rep. Koutoujian	The Department of Public Health be required to hold public hearings before the removal of publicly-funded beds under the jurisdiction of the Commonwealth. *(Filed 12/19/05; did not pass by end of regular session, 2006)*
MN HF 1380/ SF 1297 Solberg	Human services; extends deadline for a nursing facility moratorium exception project in Aitkin County. *(Filed 2/28/05; did not pass by end of regular session, 2005)*
MN HF 1422 Rep. Bradley	To modifying license fees, state-operated services, nursing facility reimbursement, children and families programs, and other provisions; providing positive abortion alternatives; and appropriating money. *(Filed 2/28/05; did not pass by end of regular session, 2005)*
MN HF 1862 Rep. Abeler	Creates evidence-based practice standards, achieves cost-containment measures, allows discounted payments, modifies other health insurance provisions and appropriates money. *(Filed 3/16/05; did not pass by end of regular session, 2006)*
MN HF 3933 Rep. Westrom	Hospital construction and modification moratorium and public interest review requirements for hospitals eliminated. *(Filed 3/27/06; did not pass by end of regular session, 2006)*
MN SF 2232/ HF 2360 Sen. Belanger	Nursing home bed moratorium exception project deadline extension. *(Filed 4/18/06; did not pass by end of regular session, 2006)*
MN SF 2576/ HF 3049 Sen. Sparks	Ambulance purchase and lease regulations; hospital construction proposals; alternative approval process, etc. *(Filed 5/26/06; passed House 5/20/06; passed Senate 5/20/06; signed into law by Governor 5/26/06)*
MS HB 082/HB 083 Rep. Woods	Removes all except specialty hospitals from application of certificate of need law; Authorizes construction of new acute care hospital. *(Filed 1/3/06; died in committee 1/31/06)*
MS HB 296 Rep. Flaggs	Certificate of need; authorizes nursing home for disabled adults. *(Filed 1/5/06; died in committee 1/31/06)*
MS HB 452 Rep. Fillingane	Nursing homes may add up to 60 new beds if have 95% occupancy rate. *(Filed 1/6/06; died in committee 1/31/06)*
MS HB 457 Rep. Fillingane	Repeal sections 41-7-171 through 41-7-209 from Mississippi Code of 1972, which are the Mississippi Health Care Certificate of Need Law of 1979 etc. *(Filed 1/6/06; died in committee 1/31/06)*
MS HB 389 Rep. Holland	To amend sections 41-7-173 and 31-7-191 from Mississippi Code of 1972 regarding hospices requiring a health care certificate of need by the State Department of Health. *(Filed 1/10/06; died in committee 1/31/06)*
MS HB 599 Rep. Holland	To require the Division of Medicaid to allow certain faith-based assisted living facilities to participate in the Medicaid Assisted Living Waiver Program and related purposes. *(Filed 1/10/06; died in committee 2/28/06)*

MS HB 600 Rep. Robinson	Amends section 41-7-191 of Mississippi Code of 1972 to issue a certificate of need for the addition of hospital beds. *(Filed 1/10/06; died in committee 1/31/06)*
MS HB 601 Rep. Martinson	Amends section 41-7-191 of Mississippi Code of 1972 to authori... a health care certificate of need for ICF-MR beds in community living programs for developmentally disabled adults. *(Filed 1/10/06; died in committee 1/31/06)*
MS HB 1095 Rep. Young	For the State Department of Health to provide a health care certificate of need for Psychiatric Residential Treatment Facility beds to be transferred; etc. *(Filed 1/16/06; died in committee 1/31/06)*
MS HB 1221 Rep. Compretta	Relates to moving nursing home beds from one facility to another; etc. *(Filed 1/16/06; passed House 3/22/06; passed Senate 3/22/06; signed into law by Governor 3/29/06)*
MS HB 1231/HB 1232/HB 1234 Rep. Flaggs	Relates to an ambulatory surgical facility; certain offices of private physicians shall require certificates of need; Revises the list of activities that require certificates of need. *(Filed 1/16/06; died in committee 1/31/06)*
MS HB 1283 Rep. Baker	Specifies requirements for issuance of CON for relocation of a health care facility. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2011/SF 2018 Sen. Thomas	Certificate of Need Program for ICF/MR beds in a community living program for developmentally disabled adults; Nursing facility beds at "Green House Model" campus located in Yazoo city. *(Filed 1/4/06; died in committee 1/31/06)*
MS SB 2453 Sen. Nunnelee	Certificate of Need Program for community living program for developmentally disabled adults in Madison County. *(Filed 1/10/06; died in committee 1/31/06)*
MS SB 2482 Sen. Thomas	Clarifies Certificate of Need Program for the relocation of a health care facility. *(Filed 1/12/06; died in committee 1/31/06)*
MS SB 2522 Sen. Jackson	Creates an establishment for the Home Health Agency in Kemper County. *(Filed 1/12/06; died in committee 1/31/06)*
MS SB 2593 Sen. Burton	Relates to certificates of need that will transfer ICF/MR and child psychiatric beds from one facility to another. *(Filed 1/13/06; died in committee 1/31/06)*
MS SB 2645 Sen. Brown	Medicaid reimbursement for nursing facility beds under Certificate of Need Programs in Columbus. *(Filed 1/13/06; died in committee 1/31/06)*
MS SB 2650 Sen. Lee	Relates to psychiatric treatment facility beds in Simpson County. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2661 Sen. Burton	Clarifies definition of ambulatory surgical facilities under Certificate of Need Program. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2675 Sen. Nunnelee	Revises definition of ambulatory surgical facilities and licensure under Certificate of Need Program. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2731 Sen. Nunnelee	Relates to health care facility activities under Certificate of Need Program. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2750 Sen. Dawkins	Would impose a certificate of need moratorium on specialized programs offered by hospitals. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2844 Sen. Horhn	Would authorize a certificate of need program for a nursing facility in any undeserved minority zip code area in the state. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2850	Would move nursing home beds from one facility to another and to construct another facility. *(Filed 1/16/06; died in committee 1/31/06)*

Sen. Kirby	
MS SB 2959 Sen. Lee	Would transfer certificates of need from Hancock to Stone and other counties. *(Filed 1/16/06; died in committee 1/31/06)*
MO HB 1537 Rep. Shaaf	Refers to 'long-term care facilities' for the purpose of the Certificate of Need Program and limits application of certificate of need requirements to long-term care facilities. *(Filed 1/25/06; did not pass by end of regular session, 2006)*
NJ AB 1469 Asmb. O'Toole	Requires certain background checks for assisted living administrators and applicants for certificate of need. *(Filed 1/10/06; Referred to committee 2/2/06)*
NJ AB 2691 Asmb. Stanley	Prohibits granting certificates of need for hospital closures in service areas with high incidence of morbidity unless DHSS has plan to manage public health emergency. *(Filed 2/23/06; Referred to committee 2/27/06)*
NJ ACR 120/SCR 53 Asmb. Van Drew	Urges DHSS to allocate 25% of new slots that are available in FY 2006 under Enhanced Community Options waiver to assisted living program providers. *(Filed 1/17/06; Referred to committee 2/26/06)*
NY AB 3263 Rep. Gottfried	To amend the public health law, in relation to nursing home staffing levels. *(Filed 2/1/06; Referred to committee 2/1/06)*
NY AB 3266 Rep. Gottfried	To amend the public health law, in relation to a nurse staffing centers; Additional powers and duties for the Commissioner of Health; Authorizes such commissioner to establish an advisory committee to advise in related issues; etc. *(Filed 2/1/06; Referred to committee 2/1/06)*
NY AB 3928 Rep. Brennan	An act to amend the mental hygiene law, in relation to establishing minimum staffing ratios in facilities operated under the jurisdiction of the office of mental health. *(Filed 2/7/06; Referred to committee 2/7/06)*
NY AB 5346 Rep. Gottfried	An act to amend the public health law, in relation to hospital establishment. *(Filed 2/18/06; Referred to committee 2/18/06)*
NY AB 11920/ S 7494 Rep. Gottfried	Relates to the limitation on the number of continuing care retirement community beds in the state. *(Filed 6/16/06; passed House 6/23/06; passed Senate 6/23/06)*
NY SB 3943 Sen. Oppenheimer	Requires health commissioner to make certain findings concerning access to health care services as a prerequisite to approving applications for establishment, incorporation or construction of certain health care facilities. *(Filed 4/5/05; Referred to committee 4/4/05)*
NY SB 4572 Comm. for Public Hlth.	Establishes minimum staffing levels of types of various personnel in nursing homes throughout any particular day; creates the advisory council on nursing home staffing to make recommendations to the governor, legislature and commissioner of health on nursing home staffing; requires public disclosure by each nursing home of its staffing levels and reporting thereof to the department of health. *(Filed 4/15/05; Referred to committee 4/15/05)*
NY SB 5718/AB 8877	Relates to increasing availability of services in certain assisted living programs. *(Filed 6/15/05; passed Assembly 6/23/05; passed Senate 6/23/05; signed into law by Governor Chapter 593, 8/23/05)*
NY	The Commission on Health Care Facilities in the 21st Century report proposes major adjustments in existing facilities including closings and downsizing. **A Prescription for New York City's Health Care Crisis:** Recommendations of the New York City Council Hospital Closing Task Force. *(Report issued 11/06; implementation pending 1/07)*
NC HB 905 Rep. Culpepper	To amend the Certificate of Need Laws. *(Filed 3/24/05; referred to committee 4/6/05)*
NC HB 1060 Rep. Wright	To change the definition of "Critical Access Hospital" to conform to federal law. *(Filed 3/30/05; passed House 4/13/05; passed Senate 8/23/05; signed into law by Governor 9/02/05)*
NC HB 2375	To appropriate funds to the Department of Health and Human Services, Division of facility services, to enhance fair and consistent application of the certificate of need law and health planning process.

Rep. Nye	*(Filed 5/22/06; Referred to committee 5/23/06)*
NC SB 740 **Sen. Rand**	To amend the Certificate of Need Laws. *(Filed 3/21/05; passed House 7/13/05; passed Senate 8/16/05; signed into law by Governor 8/26/05)*
NC SB 1161/HB 1112 **Sen. Apodaca**	Requires the Department of Health and Human Services to develop a central registry of available beds in mental health facilities to assist in the placement of individuals involuntarily committed to the facilities. *(Filed 3/23/05; did not pass by end of regular session, 2006)*
PA HB 2443 **Rep. Killian**	Relates to health care; delegating responsibilities to the State Health Coordinating Council, etc., providing certificates of need for health care providers and prescribing penalties, etc. *(Filed 2/8/06; Referred to committee 6/13/06)*
PA SB 1253 **Sen. Greenleaf**	Exempts continuing care retirement communities from the medical assistance bed approval process and allowing nursing facilities operated by continuing care retirement communities to obtain medical assistance certified beds under limited terms and conditions. *(Filed 6/22/06; Referred to committee 6/22/06)*
RI HB 5868 **Rep. Landroche**	Relating to Businesses and Professions, Board of Medical Licensure and Discipline, and self-referral. *(Filed 3/1/05; Did not pass by end of regular session, 2005)*
RI HB 5870 **Rep. Lewiss**	Relates to health and safety and the licensing of health care facilities. *(Filed 3/1/05; Did not pass by end of regular session, 2005)*
RI HB 5915 **Rep. Savage**	Relates to determination of need for new health care equipment and new institutional health care institutions. *(Filed 3/1/05; Did not pass by end of regular session, 2005)*
RI HB 7622 **Rep. Long**	Relates to determination of need for new health care equipment and new institutional health care institutions. *(Filed 2/16/06; Did not pass by end of regular session, 2006)*
RI HB 8055 **Rep. Long**	Determination of Need for New Health Care Equipment and New Institutional Health Services *(Filed 5/2/06; passed House6/22/06; passed Senate 6/23/06); signed into law by Governor, 7/5/06)*
RI HB 8246 **Rep. Slater**	Amends the definitions section, review and approval section, procedures for review section, and application fees section in the "Determination of Need for New Health Care Equipment and New Institutional Health Services" *(Filed 6/15/06; Did not pass by end of regular session, 2006)*
RI SB 426 **Sen. Gibbs**	To analyze applications for certificate of need. *(Filed 2/10/05; Did not pass by end of regular session, 2005)*
RI SB 784 **Sen. Roberts**	Amends sections in the Determination of Need for New Health Care Equipment and New Institutional Health Services. *(Filed 2/17/05; Did not pass by end of regular session, 2005)*
RI SB 798 **Sen. Badeau**	Relates to self-referral by medical practitioners; remove the capital cost test for application/installation or radiologic equipment. *(Filed 2/17/05; Did not pass by end of regular session, 2005)*
RI SB 2741 **Sen. Roberts**	To reduce the size and make-up of the health services council. *(Filed 2/14/06; passed House 6/23/06; passed Senate 6/22/06; signed into law by Governor 7/5/06)*
SC HB 3601/SB 582 **Rep. Pitts**	Relates to the State Health Planning Committee including the development and contents of the state health plan for use in the Administration of the Certificate of Need Program, so as to require the state health plan to include a provision that the Department of Health and Environmental Control shall approve a certificate of need application for open heart surgery if the applicant meets certain criteria. *(Filed 2/22/05; Referred to committee 2/22/05)*
SC SB 1054 **Sen. Peeler**	Relates to the State Health Planning Committee including the development and contents of the state health plan for use in the approval of certificates of need, including a certificate of need for methadone treatment facilities; provides that a certificate of need is required for the acquisition of certain medical equipment. *(Filed 1/18/06; Referred to committee 1/18/06)*
SC SB 1260	Relates to certificate of need requirements for home health agencies, so as to exempt from these requirements private duty home care agencies that participate in state-funded waiver programs, that

Sen. Hutto	continuously have provided these services since January 1, 2001, and that are accredited by the Joint Commission for the accreditation of health care organizations. *(Filed 3/16/06; Referred to committee 3/16/06)*
TN HB 228/SB 1751 Rep. Overbey	To increase state expenditures to the extent the replacement facility increases the nursing home bed pool, there could be an increase in the number of beds. Such an increase could result in an increase in expenditures exceeding $1,000,000 ($360,000 in state fund and $640,000 in federal funds). *(Filed 2/1/05; passed House 94y-0n, 5/22/05; passed Senate 32y-0n, 5/4/05; signed into law by Governor as Chapter 385, 5/23/05)*
TN HB 1088/SB 1007 Sen. Ford	Concerns hospitals and health care facilities; revises certificate of need requirements for relocation and partial replacement of nursing home beds and facilities. *(Filed 2/4/05; passed House 93y-0n 5/27/05; passed Senate 30y-0n 5/19/05; signed into law by Governor as Public Chapter 445, 6/24/05)*
TN HB 1112/SB 687 Rep. McMillan	Prohibits issuance of certificates of need for new nursing home beds between July 1, 2005 and June 30, 2007, except for certain Medicare skilled nursing facility beds. *(Filed 2/4/05; passed House 97y-0n, 5/12/05; passed Senate 31y-on, 4/28/05; signed into law by Governor as Chapter 237, 5/27/05)*
TN HB 1986/ SB 2113 Rep. Harmon	Exempts PACE program from certificate of need required to provide nursing home *(Filed 2/17/05; Referred to committee 3/30/05)*
TN HB 2010/SB 2103 Sen. Strader	Imposes a one-year moratorium on certificates of need for non-residential methadone treatment facilities. *(Filed 2/17/05; Referred to committee 4/17/05)*
TN HB 2211/SB 1551 Rep. Buck	Changes the maximum time allowed for reviewing agencies to report concerning a certificate of need application to the health services and development agency from 60 to 50 days. *(Filed 2/3/05; Did not pass by end of regular session, 2005)*
TN HB 3324/SB 3349 Rep. Finney	Clarifies that applications for a certificate of need shall be filed within five business days from the date of publication of the letter of intent. *(Filed 2/16/06; Referred to committee 3/5/06)*
TN SB 2958/HB 3026 Sen. Cooper	Increases the total number of beds in ICF/MR facilities that have been providing state-contracted services to persons with developmental disabilities for at least five years by 50 beds per year for the next four years after July 1, 2006. This change would result in a maximum of 868 beds by June 30, 2009. *(Filed 2/15/06; passed House 98y-0n 5/11/06; passed Senate 32y-0n 4/20/06; signed into law by Governor as Chapter 761, 5/25/06)*
VT HB 35 Rep. Obuchowski	Health; health care administration; health facilities; discontinuance of services; licensing of hospitals; open meetings; public records; certificate of need; hospital budgets. *(Filed 1/13/05; Referred to committee 1/13/05)*
VT HB 450 Rep. Hube	To reform Vermont's Certificate of Need Laws. *(Filed 3/8/05; Referred to committee 3/8/05)*
VT HB 567 Rep. Keenan	Relates to exemption from certificates of need and HMO requirements for PACE. *(Filed 1/20/06; passed House 2/3/06; passed Senate 2/3/06; signed into law by Governor 2/15/06*
VA HB 267 Rep. Cole	Authorizes the submission of an application for an increase in nursing home beds, either on-site or through relocation within the same city or county, for a facility that was licensed for less than 40 beds under certain specific conditions. *(Filed 1/4/06; passed House 98y-1n, 2/14/06; passed Senate 40y-0n, 3/7/06; signed into law by Governor as Chapter 816, 4/6/06)*
VA HB 381 Rep. Suit	The bill authorizes the facility to request an amendment to its previous certificate of public need to admit persons, other than residents of the cooperative units, to its nursing home facility beds. The facility must be: (i) operated by an association described in § 55-458; (ii) created in connection with a real estate cooperative; and (iii) providing its residents a level of nursing services consistent with the definition of continuing care in Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2. *(Filed 1/6/06; passed House 94y-0n, 1/24/06; passed Senate 40y-0n; 3/6/06; signed into law by Governor as Chapter 776, 4/6/06)*
VA HB 1139 Rep. Cline	Requires the Board of Health to develop staffing regulations specific to entities that are concurrently licensed as a hospice and an assisted living facility that would not require the presence on each shift of a registered nurse for any concurrently licensed facility that has no more than four beds and operates

	within an integrated healthcare system. *(Filed 1/11/06; Died in committee 1/24/06)*
VA HB 2243 Rep. O'Bannon	Revises the designation of the parties to the case if an informal fact-finding conference is determined to be necessary by the Department of Health or is requested by a person seeking good cause standing. In such cases, the designation of the parties to the case will include the relevant health planning agency. *(Filed 1/11/05; passed House 96y-0n, 2/7/05; passed Senate 40y-0n 2/22/05; signed into law by Governor as Chapter 404, 3/21/05)*
VA HB 2316 Rep. Griffith	Certificate of Public Need; relocation of certain nursing home beds under limited circumstances. *(Filed 1/11/05; passed House 79y-17n, 1/26/05; passed Senate 38y-1n, 2/21/05; signed into law by Governor as Chapter 99, 3/24/05)*
VA HB 2639 Rep. Hurt	Requires the Commissioner of Health to reissue a Request for Applications for 60 new nursing home or nursing facility beds in Planning District 12 when the scheduled construction date has passed, the company issued a certificate pursuant to a 1997 Request for Applications has not begun construction, and the certificate has expired. *(Filed 1/12/05; passed House 97y-0n, 2/1/05; passed Senate 40y-0n, 2/14/05; signed into law by Governor as Chapter 838, 3/26/05)*
VA HB 2826/ SB 1237 Rep. Orrock	Authorizes DMHMRSAS to license providers of services under the Medicaid Brain Injury Waiver and providers of residential services for persons with brain injury. The bill requires the State Board of Mental Health, Mental Retardation and Substance Abuse Services to promulgate necessary regulations within 280 days of enactment. *(Filed 1/19/05; passed House 94y-2n, 2/8/05; passed Senate 40y-0n, 2/22/05; signed into law by Governor as Chapter 725, 3/25/05)*
VA SB 426 Sen. Lambert III	Defines "reduced rate," for the purpose of the Commissioner's conditions on approval of a certificate of need. *(Filed 1/11/06; Died in committee 1/19/06)*
VA SB 839 Sen. Cuccinelli	Requires the regulation of abortion clinics as a category of outpatient surgical hospital and sets forth the requirements for the licensure of abortion clinics in a new article. Abortion clinics will not be required to comply with certificate of public need requirements or health care data reporting. The provision becomes effective on January 1, 2006. *(Filed* 1/3/05; Referred to committee 2/3/05)
WA HB 1688 Rep.	Creating a task force to review the certificate of need program and the health care facilities bonding program. *(Filed* 2/2/05; *passed House 71y-25n, 3/14/05; passed Senate 34y-11n, 4/7/05; signed into law by Governor as Chapter 283, 5/4/05)*
WA SB 5178	Establishes a moratorium on licensing physician owned specialty hospitals, from Jan 1, 2005 to July 1, 2006. *(Filed 1/17/05; passed Senate and House; signed into law by governor as Chapter 39, 4/13/06)* |
WA SB 6278	Relates to licensing specialty hospitals. *(Filed 1/10/06; favorable report 2/1/06; did not pass by end of session 3/06)*
WV HB 4682 Rep. Amores	Establishing standards for and guidance to the West Virginia Health Care Authority in amending and modifying certificate of need standards. *(Filed 2/21/06; Referred to committee 2/21/06)*
WV SB 569 Sen. Caruth	Exempting ventilator beds from certificate of need requirement. *(Filed 2/15/06; Referred to committee 2/15/06)*
WV SB 745 Sen. Bowman	Authorizing certain nursing homes to obtain certificates of need for additional beds. *(Filed 2/20/06; Referred to committee 2/20/06)*
WV SB 773 Sen. Kessler	Establishes certificate of need standards. *(Filed 2/22/06; passed House 3/10/06; passed Senate 3/1/06; signed into law by Governor as Chapter 101, 3/23/06)*
WY SB 57	Provides for a study of medical specialty centers and new general hospitals by the Wyoming health care commission. Provides a temporary moratorium on licensing of new hospitals or medical specialty centers, requires a report by November 2006; provides an appropriation *(Filed 1/24/06; passed Senate and House; signed into law by governor as Chapter 112, 3/24/06)*

Researched and written by Ariel Vistaroff for the NCSL Health Program. Initial edition, August 2006
Research and updates under the direction of Richard Cauchi, Health Program Director, Denver, Colorado

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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 study by Christopher J. Conover and Frank A. Sloan in 1998 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 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,

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[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.
[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.

TESTIMONY

Presented to the

Interim Health Committee on Certificate of Need

October 8, 2007 @ 3:00-4:00 p.m.

by

Wes Cleveland, JD, American Medical Association

Chairman Foster, Chairman Michael and ladies and gentlemen of the Interim Health Committee on Certificate of Need (Committee), my name is Wes Cleveland. I am an attorney who works in the American Medical Association's (AMA) Department of State Legislation. For the past four years I have spent much of my time monitoring national legislative and regulatory certificate of need (CON) developments. I appreciate the opportunity to share with you some of the trends that I have seen, and some of the information I have gathered about CON from reviewing the academic literature and recent state legislative CON studies. I also want to give you a brief sense of how your state's CON program compares with other states.' I hope that the information I will share with you will be useful as you think about your state's CON program and its future direction.

A. Landscape of CON programs and trends

Before I discuss the findings of CON studies, I would like to give you a sense of the differing types of CON programs out there and legislative and regulatory trends. Although 36 states have some type of CON program, state programs can vary widely. Some CON programs apply to a broad range of health care facilities and health services. Within these states, there can, however, be a significant difference in the monetary

thresholds that trigger the application of CON requirements, with some thresholds being "dollar zero" and others being set at millions of dollars, both for facilities and major medical equipment acquisition. A number of other states have, however, more narrowly circumscribed statutes. For example, Florida's program only applies to hospitals, long-term care facilities, hospices, and ICF-MRs. Nebraska's, Oklahoma's, and Ohio's CON programs only apply to long-term care facilities. Illinois' program applies only to health care facilities. At the extreme is Wisconsin, which while having a CON program "on the books," has not had an active CON program for the last 12 to 15 years.

In terms of regulatory and legislative trends, very little has occurred in terms of CON expansion. There have been legislative proposals to reintroduce CON programs in repeal states, but these have made very little headway. At the same time, there has also been little in the way of restricting the scope of CON programs.

Concerning your state's CON program, it appears to me that it is one of the most comprehensive state CON programs. For example, only Alaska, New York, and North Carolina regulate more services (28 to West Virginia's 27). In terms of restrictiveness, the American Health Planning Association ranks the West Virginia CON program as the fifth most restricting CON program in the U.S. ***As you will see, restrictiveness correlates with increased health care costs.***

I would now like to share some thoughts with you about the central findings of a wealth of study concerning CON.

A. CON does not control health care costs.

There is a compelling body of peer-reviewed academic research spanning over three decades, and state legislative-commissioned CON studies, demonstrating that CON programs have failed to achieve their purported purpose-- to restrain health care costs. In fact, there is evidence showing that CON programs have actually *increased* health care costs. A few examples will be sufficient to prove this point, and while there is a wealth of academic CON literature showing that CON has not achieved its objectives, I will generally confine my references to recent state legislative CON studies with the hope that they might be the most relevant to you.

The only academic study I will mention today was the result of a major research project. Published in 1998 in the Journal of Health Politics, Policy and Law by Conover and Sloan, this study was entitled "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?" The study examined the purported cost-control claims of CON over a twenty-year period, and focused on whether *CON repeal led to increased health care costs*. The study concluded, "There is no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations." A number of state legislative-commissioned studies have reached similar findings. For example, a February 2007 CON study prepared by the Lewin Group at the request of the Illinois Legislature and entitled "An Evaluation of Illinois' Certificate of Need Program," concluded that "A review of the evidence indicates that CONs rarely reduce health care costs, and on occasion, increase cost in some states." [Page 16]. In November 2006, pursuant to a request from the Georgia Legislature, the Center for the Report of Data Analyses of

Georgia State University submitted a 264-page "Report of Data Analyses to the Georgia Commission on the Efficacy of the CON Program" (the Georgia Legislature created the Commission). This report concluded, "Across all markets, states ranked as having the most rigorous CON regulation have statistically significantly less competition than non-CON states....Lower levels of competition are associated with higher costs." [Page 7]. That report also found that "CON regulation is associated with higher private inpatient costs." [Page 8]. Still another example is the CON study performed by the Missouri Senate Interim Committee on Certificate of Need released in December 2006. This study found that "Certificate of need acts as an artificial barrier to entry stifling competition and innovation in the healthcare market... Not only does this lead to higher healthcare costs but it also limits patient choice." [Page 13]. There are many other peer-reviewed academic studies that I could cite that have concluded that CON has either failed to control, or has actually increased, health care costs, and I will be happy to provide you with references if that would be helpful to you.

B. CON is not an effective quality improvement mechanism.

Although CON programs were not developed to address quality concerns, some have proposed that CON can promote quality. These quality claims have also been closely examined, and the results are, at best, inconclusive. For example, the Georgia legislative study referenced earlier stated, "There is considerable variation on a number of dimensions of quality across markets. However, there is no apparent pattern with respect to Certificate of Need regulation and no statistical correlation." [Page 9]. The Lewin

Group's report for the Illinois Legislature similarly concluded that, concerning the ability of CON laws to increase the quality of care,

> even the strongest supporters of maintaining the program agree that the area where CON can directly influence quality is narrow....CON laws' impact on quality and care is limited.

[Page ii]. An earlier study from 1999 performed by the Washington State Joint Legislative Audit and Review Committee entitled "Effects of Certificate of Need and Its Possible Repeal," likewise stated, "The evidence is weak regarding the ability of CON to improve quality by concentrating volume of specialized services." [Page 3].

C. CON does not improve access to care.

There is little evidence that CON positively affects access to care. For example, in 2003 the Michigan Department of Community Health commissioned two noted CON public policy scholars at Duke University to evaluate Michigan's CON program. That study, entitled "Evaluation of Certificate of Need in Michigan," found that "CON has limited ability to impact the overall cost of health care or to address issues raised by care for the uninsured and underinsured." [Page 132]. The 2007 Illinois legislative study performed an extensive economic analysis that compared the profit margins of safety-net hospitals in CON-states with safety-net hospitals in non-CON states. The study concluded that its collective research and analysis "do not support the argument that CONs provide a protective effect for safety-net hospitals' financial status" [Page 28] The Georgia legislative commission study found that CON's affect on access was no more than "mixed." [Page 72]. Academic literature examining CON's purported affect on access has reached similar conclusions.

D. Conclusion

In summary, 36 states have some form of CON law. Of those states, West Virginia ranks in the top five in terms of restrictiveness, which is contrary to the national trend of not expanding CON programs. Therefore, based on state legislative CON activity that I have been following for several years, I can tell you that West Virginia's recent decision to authorize a more restrictive CON rule is not in the norm.

I applaud the West Virginia Legislature for its willingness to evaluate its CON Laws, as a number of other state legislatures have recently done. Such an evaluation may be particularly appropriate now, since conclusive evidence demonstrates that CON does not control and may add to health care costs, CON is not an effective means of quality improvement, and CON does not promote access to health care. As the Illinois legislative report perhaps stated best "our results are consistent with a body of literature that indicates CON rarely achieves its stated goals." [Page 28]. I hope that you find this information useful as you think about your own state's CON program.

Thank you

Certificate of Need hinders health care innovation

1. **Posted by The Birmingham News October 14, 2007 2:00 AM**

By MICHAEL MORRISEY and MICHAEL CIAMARRA

Entrepreneurs and innovators are developing new ways to deliver health care that are more convenient, higher 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 that stagger the imagination.

Unfortunately, bureaucratic relics of the past often stand in the way of developing a 21st century, intelligent health system.

Alabama's Certificate of Need is an amazing program that requires hospitals, nursing homes and other medical facilities such as ambulatory surgery centers and diagnostic imaging facilities to have the explicit approval of the state before they can operate. When implemented in the 1960s and 1970s, CON was intended to control rising health-care costs that resulted from cost-based reimbursement.

What is amazing is that there is virtually no rigorous empirical evidence that the program has been effective in reducing hospital or health-care costs and some evidence that it increases costs. This was true in the heyday of the program in the 1980s and is still true in more recent evaluations. Yet, CON continues to exist for hospitals in Alabama and 25 other states and effectively limits new hospital construction and even needed renovation.

Consumers don't save money as a result of the CON program. Currently, hospitals and other protected providers argue that CON

keeps new providers from coming in and taking the profitable patients. It certainly does. Another way to say this is that existing providers are collecting prices which are higher than their costs and probably higher than the new entrants would charge. So, by their own admission, we pay higher prices.

CON provides less choice and less innovation.

Entry of new ambulatory surgical providers is no trivial issue. We all have friends or family members who have had an ambulatory procedure performed that only a few years ago would have required a day or more in the hospital. The American Hospital Association reported that in 2004, there were more than 1.7 outpatient surgeries conducted in U.S. hospitals for every one surgery that required an overnight stay. Ambulatory surgery centers represent a competitive alternative to hospitals for these outpatient procedures.

Nationally, recent research suggests that on average, every free-standing ambulatory center per 100,000 population in a metropolitan area is associated with a reduction of 4.3 percent in the number of hospital-based outpatient procedures. The battle in Georgia was over entry of new providers and choices and ultimately over who gets the patients. In states like Georgia, North Carolina and Alabama, the CON agency plays a big role in deciding who gets the patients and what access those patients have to new technology.

CON is not only focused on keeping out new forms of health care delivery, it is also concerned with how, or even if, existing providers can serve their communities. One need look no further than the burgeoning U.S. 280 corridor in Birmingham or the growth in Madison County near Huntsville to appreciate that many people in increasingly congested areas of the state now have longer travel times to get to a hospital.

In both communities, existing hospitals (and new providers) would

almost certainly be willing to build in the growth corridor. Much of what stops them is the CON process. Any proposed action will be opposed by existing hospitals in the community because of the threat to their established patient flow. So, in addition to the usual construction and operating costs, an effort to expand will be tied up with CON hearings, decisions, appeals and more appeals.

Finally, Alabamians needn't be reminded of the embarrassment of a former governor and a former hospital CEO who were convicted in a federal bribery case associated with an appointment to the Alabama CON board.

Regulatory agencies that provide protection from market competition and thereby offer the potential for substantial profits are tempting targets for unscrupulous politicians, bureaucrats and businesses. These temptations can be overcome with sufficient monitoring and careful processes, but it seems foolish to go through all of that for a program that doesn't provide benefits to the citizens of the state.

The CON program never controlled costs and has become a mechanism to limit competition in health care, making all of us worse off. Alabama's CON is a hindrance. Seven years ago, The Birmingham News noted, "It's time Alabama consider whether CON should be tossed into the dump heap." It's past time. It's time now for the Legislature to dismantle CON completely.

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Competition in Healthcare and Certificates of Need

MARK J. BOTTI
Chief, Litigation I Section
U.S. Department of Justice, Antitrust Division

Before A Joint Session of
The Health and Human Services Committee of the State Senate
and
The CON Special Committee of the State House of Representatives
of the General Assembly of the State of Georgia

February 23, 2007

Good afternoon. I want to thank Chairman Thomas and Chairman Cooper for their invitation to the Antitrust Division of the U.S. Department of Justice to appear before you today and to share our views on the impact of Certificate of Need ("CON") laws on healthcare markets.

My name is Mark Botti. I am the Chief of the Litigation I Section of the Antitrust Division. My group has approximately 30 attorneys and additional staff dedicated to enforcement of the antitrust laws and advocacy of the importance of competition in a number of sectors of the nation's economy. In particular, we focus to a substantial degree on

healthcare markets. In doing that work, we confer closely with a large team of Antitrust Division 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 also have dedicated time to the study of healthcare markets.

My remarks today are built on the work of these professionals and the Antitrust Division's decades long focus on healthcare markets. Over those years, we have brought many 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 understand the competitive forces that drive innovation in and contain the costs of healthcare. We consult regularly with federal and state agencies responsible for the delivery of healthcare services and the setting of healthcare policy. Our attorneys and economists study the latest academic and policy works in healthcare on an ongoing basis. We have on many occasions met informally and formally with experts in the field. For example, in the first half of the 1990s, the Federal Trade Commission and the Antitrust Division committed substantial resources to the study of competitive markets, out of which effort we prepared a series of nine antitrust enforcement principles that guide industry behavior today.(1) I worked on those enforcement statements and am directly responsible for their application. More recently, 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.(3) I oversaw the Antitrust Division's work on those hearings and that report and am the designated point of contact at the Division regarding the report.

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 proper performance of healthcare markets. Indeed, by their very nature, CON laws create barriers to entry and expansion and thus are anathema to free markets. They undercut consumer choice, weaken markets' ability

to contain healthcare costs, and stifle innovation. We have examined historical and current arguments for CON laws. They do not provide an economic justification for depriving consumers of the benefits of free markets. To the extent non-economic goals are pursued, the use of CON laws to help pursue them imposes substantial costs. Those goals can be better achieved through other mechanisms. I will explain our reasoning in more detail in just a moment; but first allow me to respectfully suggest to you our bottom line -- we hope you will carefully consider the substantial costs that CON laws impose on consumers as you evaluate whether to reform those laws in your state.

I have not come here today to discuss the details of any particular proposal before you for the reform of Georgia's CON laws. 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. For your convenience, I am leaving with you the written text of these remarks with citations to relevant sources included.

In offering these remarks, please understand that 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 . . . ."[4] Our overall mission is to preserve and promote 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

Let me set the stage for explaining our concerns about the harm from CON laws by talking for a moment about competition in healthcare generally. No doubt there are aspects of the delivery of healthcare services that make healthcare different from other sectors of the economy. The health of any individual is a sensitive and very important matter. But in our concern over the health and well-being of our fellow citizens, we as government officials should not lose sight of a basic truth -- market forces improve the quality and lower the costs of healthcare services. Increased competition in healthcare markets

does not require us to choose between obtaining the benefits of competition or the delivery of high-quality healthcare. Competition drives innovation and ultimately leads to the delivery of better healthcare. Government intervention can undermine the ability of markets to deliver that benefit.

The proposition that competition cannot work in healthcare is simply not true. Similar arguments, made by engineers and later by lawyers, that competition fundamentally does not work in their industries and is harmful to public policy goals, have been soundly rejected and private restraints on competition have long been condemned.(5) 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 shaping the delivery of healthcare in this country. The Antitrust Division and the Federal Trade Commission have worked diligently to make sure that private barriers to that competition do not arise.(6)

During our extensive healthcare hearings in 2003, we obtained substantial evidence 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." Competition results in lower prices and broader access to health care and health insurance, and in particular non-price competition can promote higher quality.(7)

This finding is not surprising. 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.(8) Ambulatory surgery centers offered patients more

"convenient locations, shorter wait time, and lower coinsurance than a hospital department."[9] 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.[10] 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.

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.

For example, we are on the cusp of a potentially significant advance in how competition empowers consumer choice, thus delivering more quality and containing costs. In an August 22, 2006 Executive Order, the President ordered executive agencies to take steps to promote transparency in healthcare quality measures and pricing and to facilitate the development of health information technology.[11] In implementing that directive, the Department of Health and Human Services (HHS), has launched a transparency initiative for value-driven health care that aims to facilitate the delivery of better care at lower costs. Similarly, private health plans have developed products that give consumers greater choice and more information, with an eye toward improving quality while controlling costs. And new companies are entering the market seeking to provide more information and empower consumer choice in healthcare markets.[12] Capturing the promise of these initiatives, HHS has observed that "[c]onsumer choice creates incentives at all levels, and motivates the entire system to provide better care for less money."[13]

B. CON Laws Create Barriers to Beneficial Competition

CON laws are a classic government-erected barrier to entry. As such, they are anathema to competitive markets. Accordingly, in *A Dose of Competition*, the Department of Justice and the Federal Trade

Commission urged the states to rethink their CON laws.[14]

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 origins 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 expenses predominantly on a "cost-plus basis." This is a very important point. The original reason for CON laws was not, as some have argued, that competition inherently does not work in healthcare or that market forces promote over-investment. Instead, CON laws were desired because the reimbursement mechanism, i.e., cost-plus reimbursement, incentivized over-investment. The hope was that CON laws would compensate for that skewed incentive.

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

- CON laws were not adopted around the country 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, since patients were not price-sensitive, providers engaged in a "medical arms race" by unnecessarily expanding their services to offer the perceived highest quality services.[15]

CON laws appear not to have served well even their intended purpose of containing costs. Several studies examined the effectiveness of CONs in controlling costs. The empirical evidence on the economic effects of CON programs demonstrated near-universal agreement

among health economists that CON laws were unsuccessful in containing healthcare costs.(16)

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. 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.(17)

2. Protecting Revenues of Incumbents Does Not Justify CON Laws

I want to address directly one of the most prominent rationales advanced for keeping CON laws, namely, that incumbent hospitals should be protected against additional competition so that they can use their profits to cross-subsidize care for uninsured or under-insured patients.(18) 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.

The cross-subsidization rationale essentially turns these laws on their head. What started as laws intended to control costs have become laws intended to inflate prices. Ironically, proponents of CON laws now would use these barriers to entry to accomplish precisely what economic theory would predict barriers to entry usually accomplish -- stifle competition, protect incumbent market power, frustrate consumer choice, and keep prices and profits high.

Please do not misunderstand my point here. We are not accusing community hospital proponents of CON laws of seeking these barriers to entry for some improper purpose. We fully appreciate the laudatory

goal of trying to make sure that community hospitals have sufficient funding so that they 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 this laudatory purpose has costs. Importantly, to the extent legislatures choose to help cover health care costs for the indigent, 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 them 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.

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. Put another way, the evidence to date indicates that new competition does not undercut community hospitals' ability to fulfill their charitable mission. Last year, 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.[19] 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.

A third reason why CONs may do more harm than good results from the beneficial effect that new competition has on community hospitals. 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.[20] Community hospitals encouraged physicians to perform procedures on the hospital campus by developing centers of excellence and building physician offices on campus.[21] Overall, community hospitals affected by specialty hospital entry maintained profit margins in line with national averages. Rather than undercutting

community hospitals, we have seen that new entry drives them to do a better job. Thus, CON laws harm society in general by depriving it of the increased efficiency that competition would have brought to the health care market.(22)

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 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.(23) 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.(24) 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."(25)

We have found that existing competitors at times 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.(26) 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 Virgina case, two closely competing hospitals decided to use the CON process to allocate healthcare services between themselves.[27] The hospitals agreed 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.

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.[28] 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.

4. CON Laws Lead To Less Competition and Higher Prices

It is not surprising, given that the prevalent justification for CON laws is to protect the exercise of market power by existing hospitals, that studies show that the removal of CON regulation does not consistently lead to a surge in medical expenditures.[29] Indeed, as one would expect, several studies have concluded that the presence of CON regulations may be responsible for increases in healthcare costs.[30] These findings were supported by the recent study by Georgia State University conducted as part of your state's review. That study showed that rigorous CON regulation is associated with less competitive markets and higher prices for private inpatient care.[31]

III. Framework for Evaluation of CON Laws

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 Georgia should

carefully consider whether, and if yes, to what degree, its CON laws continue to serve the citizens of this state. We offer the following framework for your consideration:

First, we suggest that the enactment or continuation of CON laws should have a significant, clearly articulated justification, because they are government intervention in the marketplace that create barriers to entry into healthcare markets. That substantial justification should have a basis in serious and persuasive market studies that demonstrate that the market has failed in some significant way.

Second, any evaluation of a proposed CON law should consider not only the justification for the law but also identify and weigh the harm to consumers that is likely to result from creating the barrier to entry. The consideration of these potential harms should include the ways in which the regulations could distort the market, affect incentives, or diminish competition. A state should enact or maintain a CON law only if it finds that the justification does more good than harm.

Third, in cases where the evidence does show a greater benefit than harm from a CON law, we urge you to consider whether you can address the problem in an alternative fashion that preserves competition, or at least is narrowly tailored to remedy only the demonstrated need and preserve as much competition as is possible. A state should only use CON laws to address some problem if that problem cannot be addressed without government intervention in the form of a barrier to entry. If a state must erect a barrier to entry, select the approach that accomplishes the objective with the least disruptive effect on competition.

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. We are unaware of evidence that those states which have eliminated CON laws have suffered such harm. The studies, cited above, in fact suggest that elimination of CON laws leads to improved markets. Accordingly, we encourage you to consider carefully whether the maintenance of those laws or the enactment of new ones best serves your citizens.

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.

FOOTNOTES

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

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

3. *Improving Health Care: A Dose of Competition* (July 2004) available at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf. ("*A Dose of Competition*").

4. *See* 1996 Statements, pg. 3.

5. *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).

6. *American Medical Association v. U.S.*, 317 U.S. 519, 529 (1943).

7. *A Dose of Competition*, ch. 3 § VIII and Executive Summary at 4.

8. *Id.*, Ch. 3 at 25.

9. Medicare Payment Advisory Commission (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.

10. A Dose of Competition, Ch. 3 at 24.

11. http://www.whitehouse.gov/news/releases/2006/08/20060822-2.html.

12. See http://www.revolutionhealth.com.

13. See http://www.dhhs.gov/transparency.

14. *A Dose of Competition*, Executive Summary at 22.

15. *A Dose of Competition*, Ch. 8 at 1-2.

16. 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").

17. *A Dose of Competition* at 1-6.

18. *Id.*, Ch. 3 at 36-40.

19. *See* MedPAC 2006 Report.

20. 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).

21. 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).

22. For similar reasons, we have not found persuasive other arguments, such as community planning or quality of care as reasons for erecting barriers to entry through CON laws.

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

24. The *Noerr-Pennington* doctrine of antitrust law holds that under the First Amendment, it cannot be a violation of the federal antitrust laws for competitors to lobby the government to change the law in a way that would reduce competition. *See Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961) ("no violation of the [Sherman] Act can be predicated upon mere attempts to influence the passage or enforcement of laws"); *United Mine Workers v. Pennington*, 381 U.S. 657 (1965) ("joint efforts to

influence public officials do not violate the antitrust laws even though intended to eliminate competition").

25. *A Dose of Competition*, Executive Summary at 22.

26. *United States 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).

27. *United States v. Bluefield Regional Medical Center, Inc.*, 2005-2 Trade Cases ¶ 74,916 (S.D. W.Va. 2005).

28. 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).

29. Christopher Connover and Frank Sloan, Evaluation of Certificate of Need in Michigan (2003) (available at http://www.michigan.gov/mdch/0,1607,7-132-2945_5106-83771--,00.html).

30. Daniel Sherman, Federal Trade Commission, "The Effect of State Certificate-Of-Need Laws On Hospital Costs: An Economic Policy Analysis" (1988) (strong CON programs may increase costs); Christopher Connover and Frank Sloan, Evaluation of Certificate of Need in Michigan (2003) (available at http://www.michigan.gov/mdch/ 0,1607,7-132-2945_5106-83771--,00.html) (CON in some instances may have raised costs).

31. The Effect of Certificate of Need Laws on Cost, Quality, and Access (Georgia State University, Oct. 2006); Report of Data Analyses to the Georgia Commission on the Efficacy of the CON Program, at 9 (Nov. 2006).

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About *PH&S*

About Providence Health & Services in Alaska

May 10, 2007

Providence Health & Services (PH&S) is positioned to dominate the state's health care market indefinitely with three times more operating revenue than its closest competitor, $321 million budgeted to build new facilities between 2005 and 2008, and the former Alaska Commissioner of Health and Social Service in charge of strategic development.

PH&S Alaska operates four hospitals and many other ventures in south-central Alaska. The company has no presence outside of south-central Alaska.

According to PH&S's newly released 2006 financial statement, PH&S Alaska produces the highest profit margins of all PH&S regions. In 2006, Providence Alaska created $57 million in total profit for a 9.6% margin. While the Alaska division produces 10% of PH&S operating revenue, it generates 16% of the system's operating profit.

Providence Alaska Medical Center in Anchorage alone accounts for almost half of all hospital admissions in the state. The company employs more than 4,000 people, making it Alaska's largest private employer.

Operations

Anchorage:

Anchorage is the base for PH&S in Alaska. The company operates one of the city's two general acute care hospitals as well as long term care and assisted living facilities, the Providence Physician Service Organization, and an ambulatory surgery facility (Providence Surgery Centers, LLC). The company also recently opened the 60-bed St. Elias Specialty Hospital as a for-profit joint venture with BridgeCare, an Alabama based firm.

Providence Alaska Medical Center (PAMC)
PAMC is the largest hospital in Alaska. The 363-bed facility accounted for 42% of the state's total acute care hospital admissions in 2005—and more than half of all hospital profit in the state. PAMC provides a full range of medical, surgical, and tertiary services at the main hospital, Providence Children's Hospital, Providence Cancer Center, Providence Heart Center, and Providence Maternity Center. Providence LifeGuard Air Ambulance transports patients by helicopter from facilities around the state to PAMC. In 2005 PAMC posted $29.5 million in net profit, or a 6.8% total margin.

PH&S Alaska Hospitals – 2005*		
	PH&S hospitals avg.	Alaska hospitals avg.
Alaska Market Share by admissions	47%	n/a
Operating profit margin	4.7%	5.9%
Total profit margin	8.3%	5.5%
Occupancy Rate**	57%	56%

NOTE: PH&S Alaska figures are only for their acute care hospitals in 2005. Neither complete figures for PHS Alaska in 2005 nor hospital-level information for 2006 are available to date.
*The state of Alaska does not collect or distribute hospital financial or utilization data. Audited financial statements from each of Alaska's sixteen acute care hospitals were used to compute these figures.
** Occupancy rates were calculated using total inpatient days reported in audited financials divided by available bed days as reported in Medicare cost reports.

Mary Conrad Center
This 90-bed nursing home has been managed by Providence since 1986. PH&S Alaska describes the skilled nursing and rehabilitation services facility as a "home-like environment."

Providence Extended Care Center
This 224-bed long-term care facility is the largest in Alaska.

Beyond Anchorage:

Providence operates three municipally owned hospitals outside Anchorage—operating facilities at Seward and Valdez under management agreements and a facility at Kodiak under a lease.

Providence Seward Medical Center (PSMC)
Providence has operated a 6-bed hospital and a 43-bed long term care facility in Seward since 1996. In 2005, PSMC lost $402,000 for a -3.7% total margin.

Providence Valdez Medical Center (PVMC)
The City of Valdez pays PH&S to manage this 11-bed hospital and a 19-bed long term care facility. In 2005, PVMC lost $146,000 for a -1.9% total margin.

Providence Kodiak Island Medical Center (PKIMC)
Providence began managing this 25-bed hospital and a 19-bed long-term care facility in 1998 under a 10-year renewable lease from the Kodiak Island Borough (KIB). PH&S collects no management fee and actually pays the borough $720,000 annually for the right to operate the facility. In 2005, PKIMC posted a $769,000 profit for a 3.6% total margin.

Growth

PH&S is cementing its dominance in Alaska with a plan to spend $321 million to build a host of new facilities by 2008, including:

- new medical office buildings
- a heart institute
- another cancer center
- administrative offices
- visitor housing and
- a 40-acre commercial development that 'surrounds' the competing Mat-Su Regional Medical Center.

Expanding its strength in the long-term care market, PH&S opened the for-profit St. Elias Specialty Hospital in Anchorage on December 18, 2006. This $24 million facility, a partnership between PH&S and Bridgecare Hospitals from Alabama, is the only one of its kind in the state. St. Elias Specialty Hospital focuses on non-critical patients requiring long-term acute care, and will receive patients from hospitals throughout the state. Once St. Elias Specialty Hospital demonstrates that patients stay at the hospital an average of more than 25 days, administrators say that they will seek certification by Medicare as a long-term acute care hospital.

The State of Alaska is currently considering applications for certificates of need for seven PH&S Alaska projects totaling $48 million. The most controversial project seems to be the proposed imaging center in the Matanuska-Susitna (Mat-Su) Valley.

Providence Projects in Certificate of Need Process – May 9, 2007

Project	Status	Value
Anchorage – Cardiovascular Observation Area Expansion	Application Complete	$ 1,312,575
Anchorage - Catheterization Labs	Application Complete	$5,001,614
Anchorage - Outpatient Therapy Services	Application Received	$3,643,586
Anchorage Ambulatory Surgery Center	Hearing Scheduled	$9,600,000
Seward - Providence Wesley Care Center	CON Approved	$26,100,000
Anchorage Abbott Road Imaging Facility	Appealed	
Mat-Su Imaging Services	Appealed	
Total		$47,657,775

Matanuska-Susitna Valley Controversy

After losing a bid to partner with the Valley Hospital Association, PH&S Alaska is aggressively undermining the new community hospital in Mat-Su Valley, first by purchasing land surrounding it, and now by seeking to open a competing imaging center without Certificate of Need approval.

In 2002, the Valley Hospital Association decided to build a new community hospital in the Matanuska-Susitna Valley that could treat more patients locally. Lacking the cash to undertake the project, the association's board entertained several proposals, and ultimately entered into a joint venture with for-profit Triad Hospitals, Inc. Under the agreement, Triad agreed to spend up to $75 million on the new facility, maintain a local presence on the board of directors with 50%

of the board's vote, and proportionately share the hospital's profits with the community. The association rejected a bid from Providence out of concern that the company would push to stabilize patients and then transfer them to Providence Anchorage Medical Center rather than keeping them at "our own full-fledged hospital" said Elizabeth Ripley, spokeswoman for the Mat-Su Valley hospital. "We wanted to deliver care locally," she said.

The community broke ground on the new 74-bed Mat-Su Regional Medical Center on May 17, 2004 and opened its doors on January 27, 2006.

Shortly before the deal with Triad was approved, Providence had announced it had purchased an option to buy 99 acres of land just south of the new Mat-Su hospital. In June 2005, Providence announced that it would relocate two of its physician clinics to a new medical office building it was developing on the land. In December 2005, Providence announced a joint venture with the Imaging Associates of Providence (IAP) radiology group. The joint venture, Mat-Su Imaging Services, would locate in the new office building.

Providence did not file an application for a certificate of need for the imaging facility; but in March 2006 Norman Stephens, CEO of the new Mat-Su hospital, wrote to Health Commissioner Karleen Jackson asking the state to investigate whether or not a certificate of need was required. In doing so, Stephens said, "Mat-Su Regional Medical Center may be adversely and substantially affected by the violation of the Certificate of Need statute..."

Commissioner Jackson agreed with PH&S Alaska that the imaging facility was actually a physician's office, not a "health care facility," and was therefore exempt from the certificate of need requirements. Mat-Su appealed, arguing that "IAP does not meet the exemption for physician offices as its majority investor is a hospital, Providence Health System. Every day that IAP is allowed to continue operating its MRI is a violation of the law and financially penalizes Mat-Su Regional." (Imaging is a widely known as a lucrative health care business that acute care hospitals often resent because independent imaging operations can "cream" revenue away from a hospital's fragile service mix.)

Jackson rejected that appeal. She reversed herself, however, after a court ruled that an independent diagnostic testing facility in Fairbanks, Alaska, required a Certificate of Need. She informed IAP on August 17, 2006 that a certificate of need would be required for Mat-Su Imaging Services.

At the request of Ed Lamb, CEO of Alaska Regional Medical Center, Jackson informed Providence that IAP's Anchorage Abbott Road Imaging Facility would also require a certificate of need.

Providence appealed both decisions. Administrative Law Judge Terry L. Thurbon consolidated the cases in November 2006, and is now considering the matter.

PH&S Alaska currently owns at least 40-acres of land that surrounds the Mat Su Regional Medical Center. The former Providence employee who secured the land purchase while he worked for the hospital now holds a 10-year development agreement that gives him exclusive rights to develop the property, where he hopes to build a hotel, retail and office space, and several "destination restaurants." Asked about the property "in the vicinity of the new Valley Hospital," Providence Alaska Region CEO Parrish stated, "It's not only in the vicinity, it completely surrounds it."

Executives

Al Parrish became CEO of the Providence Alaska Region in 2002 after working in the Alaska tourism industry for the previous 20 years. In a recent interview, Parrish acknowledged PH&S Alaska's ambitious plans, saying, "It probably does give the appearance, which is an accurate appearance, that we really have a lot of irons in the fire. But the need was there and we said we will address that need." Providence reports Parrish's 2005 salary as $417,841.

Robert Dvorak earned a $338,162 salary in 2005 for his work as Providence Alaska's chief financial officer.

Susan Humphrey-Barnett is the area operations administrator for PH&S Alaska, where she is in charge of operations outside of PAMC. Her 2005 salary was $191,844.

Joel Gilbertson, former Alaska Commissioner of Health and Social Services, is now regional

THE JOURNAL OF INDUSTRIAL ECONOMICS 0022-1821
Volume XLIX March 2001 No. 1

THE COMPETITIVE EFFECTS OF NOT-FOR-PROFIT HOSPITAL MERGERS: A CASE STUDY*

MICHAEL G. VITA† AND SETH SACHER‡

Applying conventional horizontal merger enforcement rules to nonprofit hospitals is controversial. Critics contend that the different objective function of not-for-profits entities should mitigate competitive concerns about mergers involving nonprofit hospitals. We analyze a merger that reduced the number of competitors (both nonprofit) in the alleged relevant market from three to two. We find that the transaction was followed by significant price increases; we reject the hypothesis that these price increases reflect higher post-merger quality. This study should help policymakers assess the validity of current merger enforcement rules, especially as they apply to not-for-profit enterprises.

I. INTRODUCTION

ALTHOUGH RESEARCHERS have made innumerable attempts to analyze the relationship between competition (as proxied by concentration) and performance (e.g., price), empirical evidence on the actual competitive effects of horizontal mergers is scarce. Perhaps this is not surprising. When assessed by contemporary antitrust standards, most mergers (even most horizontal mergers) do not present a serious risk of competitive harm. The handful that do typically either will be blocked in their entirety, or approved conditional on the completion of some remedial action (e.g., the divestiture of a critical competitive asset to a third party) designed to ameliorate the risk of competitive harm. Hence, candidates for the study of (plausibly) anticompetitive mergers will arise only infrequently; when, for example, the enforcement agencies lose a merger challenge in court, obtaining no competitive relief, or when the enforcement agencies do not challenge a transaction for reasons unrelated to the transaction's perceived competitive effects.

* This article reflects the views of the authors, not those of Charles River Associates, the Federal Trade Commission, or any individual Commissioner. We thank Severin Borenstein, Denis Breen, Dan Hosken, Paul Pautler, Dave Reiffen, Lou Silvia, John Simpson, and participants in the FTC seminar series, for helpful comments. Kelly Flynn and Sara Harkavy provided excellent research assistance. Remaining errors are ours.

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This paper takes advantage of one of these rare opportunities.[1] We provide an econometric analysis of a horizontal merger in a concentrated hospital market, Dominican Santa Cruz Hospital's acquisition of its sole rival in the city of Santa Cruz, California, AMI-Community Hospital. According to the FTC, only two competitors—both not-for-profit—remained in the relevant market after the transaction.[2] Absent substantial efficiencies, or a credible threat of entry, standard antitrust analysis would predict that an increase in concentration of this magnitude likely would lead to higher equilibrium prices for both competitors. Consequently, this transaction would have been challenged by the FTC, had the Commission been able to intervene before the transaction was completed.[3] However, because the transaction was too small (in absolute size) to trigger the Hart-Scott-Rodino filing thresholds, the FTC did not receive prior notification of the transaction, and the parties were able to consummate the acquisition before the FTC could seek a preliminary injunction. Ultimately, the FTC entered into a consent order with Dominican Hospital, but the decree required only that Dominican notify the Commission prior to any further acquisitions in the relevant geographic market—it did not restore the premerger market structure. For this reason, this acquisition provides an excellent opportunity to assess, *ex post*, the actual, as opposed to the predicted, competitive consequences of a horizontal merger.

This study should be of interest for at least two reasons. First, as noted, empirical studies of the price effects of horizontal mergers are comparatively rare, notwithstanding their apparent importance to appraising the efficacy of federal merger enforcement policy. Studies such as this should help policymakers assess whether the enforcement decision rules embodied in the *Merger Guidelines* predict with an acceptable degree of accuracy the competitive consequences of actual horizontal mergers.

Second, and more specifically, the applicability to hospital markets of the antitrust agencies' approach to horizontal merger analysis (i.e., the *Merger Guidelines*) recently has been called into question. A substantial share of hospital output (approximately 90%) is produced by private and public nonprofit hospitals. Critics have contended that the antitrust agencies and courts have assumed that these not-for-profit providers seek maximum profits, notwithstanding the substantial body of theoretical and

[1] Both the Federal Trade Commission and the Department of Justice have unsuccessfully challenged other horizontal hospital mergers. However, these transactions are less amenable to empirical analysis than the Dominican Santa Cruz-Community merger because (1) the transactions are too recent to allow measurement of post-merger market performance, and/or (2) reliable price data do not exist.

[2] See Complaint *In the Matter of Santa Cruz Hospital, et al.* 118 F.T.C. 382 (1994).

[3] See Statement of Chairman Janet D. Steiger in Support of Final Issuance of Consent Order *In the Matter of Dominican Santa Cruz Hospital, et al.* 118 F.T.C. 382 (1994).

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empirical analyses suggesting that nonprofit entities—or more specifically, certain types of nonprofit entities—will eschew opportunities to profitably exercise market power.[4] For example (see Lynk [1995], pp. 440–41), it is conceivable that a private nonprofit hospital sponsored and administered by the local community, might function something like a consumer cooperative. If so, the incentives of producers and consumers would be aligned, and any incentives the hospital might otherwise have to raise prices anticompetitively would be attenuated. Alternatively, the behavior of a nonprofit hospital whose profits are used to fund some particular set of activities valued by the firm's managers—e.g., providing charity care to the poor——might be indistinguishable from that of an identically situated for-profit entity.

Whether the (potentially) different incentive structure of not-for-profit hospitals could attenuate the exercise of market power is of more than just academic interest. The courts that must adjudicate horizontal merger challenges also have found such arguments compelling. In at least one case,[5] a US Federal District Court found that the nonprofit, community-sponsored status of the merging parties was an important factor in rebutting an otherwise convincing *prima facie* case against the merger of two rival hospitals.

The transaction analyzed here provides an excellent opportunity to explore these possibilities. The acquiring entity (Dominican Santa Cruz Hospital) is part of a chain of Catholic hospitals operating in the western United States. Its sole remaining rival in Santa Cruz county, Watsonville Community, is a locally-sponsored community hospital. According to the arguments set forth above, Watsonville Community would appear to be the type of nonprofit hospital least prone to exercise market power; any such propensity to charge competitive prices would, moreover, place a powerful post-merger competitive constraint on Dominican's ability to raise prices. Consequently, an analysis of both entities' post-merger pricing behavior should provide a valuable insight into the behavior of nonprofit producers.

II. PREVIOUS STUDIES OF HOSPITAL COMPETITION

Many studies of hospital competition have been carried out using a variant of the 'Structure-Conduct-Performance' (S-C-P) paradigm. Early (i.e., pre-1983) studies frequently found a *negative* relationship between hospital

[4] See Lynk [1995] for a more detailed review of the relevant theory and evidence.

[5] See *F.T.C. v. Butterworth Health Corporation and Blodgett Memorial Medical Center* (US District Court, Western District of Michigan, Southern Division), September 26, 1996, slip. op. at 27.

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concentration and costs,[6] which usually was interpreted as evidence of insurance-induced moral hazard. Studies using data from the mid–1980s and after typically found a *positive* relationship between concentration and price.[7]

While suggestive, these price-concentration studies do not provide direct evidence of the effects of hospital mergers. One problem with drawing inferences about the competitive effects of mergers from this literature is that the results are almost surely sensitive to the way the geographic markets are defined, since this definition will determine the value of the concentration index.[8]

An alternative empirical strategy for assessing the consequences of merger-induced changes in market structure is to examine directly, through a comparison of the pre- and post-merger prices charged by the merged entity (and, perhaps, its plausible rivals). This 'event study' approach obviates the necessity of defining the 'relevant market.' If the merger creates market power, then (after suitably controlling for other possible shifts in the exogenous determinants of price) one should observe the merged entity raising its price post-merger. It is unnecessary to identify the relevant market to carry out this test—at minimum, one requires only data for the merged entity.

Early applications of the event study method (e.g., Barton and Sherman [1984]; Kim and Singal [1993]) used a relatively simple specification: they analyzed movements in the price of the product affected by the merger, relative to the price of a substitute product hypothesized to face similar demand and cost conditions, but unaffected by the merger. The equality of pre- and post-merger prices was then tested using a simple t test. Later implementations of the event study method (e.g., Schumann *et al.* [1992, 1997]) used a somewhat different approach—they estimated a price equation with data spanning the pre- and post-merger periods.[9] The competitive effect of the transaction was captured with a dummy variable set equal to one for the post-merger period. This method is potentially problematic if there are unobserved exogenous determinants of price that are correlated with the merger dummy. If so, the merger coefficient would reflect the competitive effects of the transaction, as well as movements in

[6] For a comprehensive review of this literature see Pautler and Vita [1994]. For seminal works see Joskow [1980] and Robinson and Luft [1985].

[7] See, e.g., Dranove *et al.* [1993]; Melnick *et al.* [1992]; Keeler, Melnick and Zwanziger [1999]; and Simpson and Shin [1998].

[8] For example, see Keeler and McClellan [1999] and Werden [1989]. Only the former have offered an alternative method for defining antitrust markets. Although there seldom may be good practical alternatives to patient flow data, it is nonetheless true that antitrust markets defined on this basis may lead to incorrect conclusions about the competitive constraints faced by a particular pair of merging hospitals.

[9] The control variables consisted of demand and cost shifters.

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these unobserved price determinants, leading one to incorrectly estimate the price effects of the transaction.

Below, we propose an empirical framework that combines elements of the Barton and Sherman, and Schumann *et al.* approaches. We believe that this strategy will provide the best method for identifying accurately the competitive effects of the acquisition. Before setting forth this empirical strategy, we first describe in greater detail the events of the Dominican-Santa Cruz transaction.

III. HISTORY OF THE TRANSACTION

On March 8, 1990, Dominican Santa Cruz Hospital ('Dominican'), a 259-bed, not-for-profit hospital, affiliated with the Catholic Healthcare West system, purchased the only other hospital in the city of Santa Cruz, AMI-Community Hospital ('Community'). Community, which was affiliated with American Medical International, was licensed for 180 beds and was a for-profit entity. Dominican and Community were located about two miles apart. Five months after the acquisition (August 1990), Community was converted completely to a nursing home/rehabilitation facility. The only other hospital in Santa Cruz county was Watsonville Community Hospital, located about 14 miles south of the city of Santa Cruz. The city of Santa Cruz is located about 40 miles south of San Jose, and 80 miles south of San Francisco. Santa Cruz county is bordered on the south and west by the Pacific ocean, and on the north and east by the Santa Cruz mountains.

Contemporaneous data on patient flows showed that the overwhelming majority (about 94%) of the three Santa Cruz county hospitals' patients resided in Santa Cruz county, and that most (about 97%) Santa Cruz residents receiving inpatient hospital care received it from hospitals in that county.[10] The patient flow data also showed that very few—less than 2.5%—of the patients at the next closest set of competitors originated in Santa Cruz county.[11] In short, there was very little evidence to suggest that residents of Santa Cruz county regarded out-of-county hospitals as good substitutes for in-county hospitals, or that Santa Cruz county hospitals sought to attract patients from outside of the county. Accordingly, the FTC's complaint alleged that the relevant geographic market was 'Santa Cruz County and/or portions of Santa Cruz County.' Only two

[10] Nine Santa Cruz county ZIP codes account for over 80% of the privately insured inpatients at the two hospitals.

[11] The next closest competitors (Community Hospital of Los Gatos and Good Samaritan Hospital) were both located in Los Gatos (Santa Clara County). Both hospitals were approximately 25 miles (41 minutes driving time) from Dominican Santa Cruz Hospital. Watsonville Hospital, by contrast, was only 14 miles from Dominican (23 minutes driving time).

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hospitals—Dominican and Watsonville Community—remained in this market post-merger. According to the Complaint, the merger increased the market share (of patient-days) of Dominican from 62% to approximately 73%, and increased the market share (of available beds) from 50% to 73%. The Herfindahl-Hirschman Index for the relevant antitrust market increased by over 1,700 points (from approximately 4,620 to approximately 6,350) when measured by patient-days; and by over 2,300 points (from approximately 3,770 to approximately 6,090) when measured by available beds. Under the *Merger Guidelines* enforcement criteria, a transaction generating concentration figures of this magnitude would be presumed anticompetitive. Absent compelling evidence that such a merger would create substantial efficiencies, or that the exercise of market power would be constrained by the threat of entry, normally the FTC would seek to preliminarily enjoin such a transaction.[12] Had the FTC had the opportunity to seek a preliminary injunction in this case, it would have done so.[13] However, as noted earlier, the small absolute size of the transaction failed to trigger the Hart-Scott-Rodino filing thresholds, and the FTC was not able to seek an enforcement action until after the transaction was completed.

In March, 1993, approximately three years after the merger was consummated, the FTC accepted a consent agreement with Dominican Santa Cruz Hospital and Catholic Healthcare West. The consent order did nothing to restore the pre-merger competitive environment; it required only that the respondents obtain the Commission's prior approval before acquiring any other hospitals in Santa Cruz County. Although all of the FTC Commissioners concluded that the merger probably had created significant market power, a majority of the FTC Commissioners concluded that the agency had few good remedies available to it.[14] The acquired hospital, Community, already had been converted to a skilled nursing/rehabilitative care facility. Thus, the effects of the merger could have been reversed only at considerable cost. Further, Sutter Health, a major Northern California hospital chain, had announced plans to construct an acute care hospital in Santa Cruz, and had already purchased a 3.8 acre

[12] According to the 1992 *Merger Guidelines* (§0.51(c)), 'the [FTC] regards markets [with HHIs above 1800] to be highly concentrated . . . [when] the post-merger HHI exceeds 1800, it will be presumed that mergers producing an increase in the HHI of more than 100 points are likely to create or enhance market power or facilitate its exercise.'

[13] As then-FTC Chairman Steiger observed at the time, '[t]he facts of this case provide sufficient reason to believe that this acquisition violates Section 7 of the Clayton Act. Ordinarily, such facts would lead the Commission to seek a preliminary injunction in federal district court.' See Statement of Chairman James D. Steiger in Support of Final Issuance of Consent Order *In the Matter of Dominican Santa Cruz Hospital, et al.* 118 F.T.C. 382 (1994).

[14] See Statements of Chairman Steiger, Commissioner Azcuenaga, and Commissioner Yao *In the Matter of Dominican Santa Cruz Hospital, et al.* 118 F.T.C. 382 (1994).

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site toward that end.[15] The FTC reasoned that entry by this entity likely would already have occurred by the time divestiture could be completed, thereby moving the market closer to the pre-merger status quo more rapidly than could be accomplished through the FTC's administrative process. As it turned out, some time in the second quarter of 1996, Sutter Health opened the Sutter Maternity and Surgery Center with 30 licensed and 21 staffed beds.

IV. EMPIRICAL ANALYSIS: METHODS AND DATA

IV(i). *Basic Price Regressions*

We begin our empirical analysis by first presenting some basic descriptive information on the behavior of prices at the two remaining Santa Cruz county hospitals. Our measure of price is derived from data supplied by the Office of Statewide Health Planning and Development (OSHPD). For each quarter (1986 through 1996, inclusive) we calculate the average net revenue received per inpatient acute-care admission (or, alternatively, per patient day[16]) for privately insured patients.[17] Of course, hospitals provide numerous inpatient services, some of which may or may not be demand- or supply-side substitutes. Nevertheless, a single measure of inpatient price is consistent with the so-called 'cluster' approach to defining hospital product markets used in virtually all hospital merger investigations.[18]

[15] *Sacramento Business Journal*, March 16, 1992.

[16] All of the estimates carried out with dependent variables defined as per-day values are available at the *JIE* Editorial website.

[17] In the OSHPD data, there are various categories for both gross and net patient revenue. Net revenue is equal to a hospital's gross revenue minus any discounts that it offers. In the data, the *gross* revenue figures distinguish between inpatient and outpatient revenue, however, the *net* revenue figures do not. As noted by Dranove *et al.* 1993], failure to account for discounts seriously understates the effect of competition on price. Thus, several adjustments must be done in order to obtain estimates of net inpatient *revenue* from the gross inpatient data. While OSHPD has been collecting quarterly data from hospitals since approximately 1980, data prior to 1986 did not in any way distinguish revenue by payor group. As a result, observations from prior to 1986 were eliminated. For data from 1986 to 1992, net inpatient price was calculated by multiplying total net revenues from non-Medicare, non-Medicaid patients by the ratio of gross *inpatient* revenue to gross *total* revenue at the hospital. While this net revenue figure eliminates Medicare and Medicaid patients it does include revenue from some patients in various non-Medicaid indigent programs. This net revenue figure is then divided by discharges to obtain the average price paid per non-Medicare, non-Medicaid acute-care inpatient. We also adjusted the number of discharges by the ratio (total revenue-bad debt/total revenue) in order to account for bad debt.

For data after 1992, patient revenue for various indigent programs is reported in a separate category. In order to keep the observations consistent over time, revenue from this category was added to the revenue figures for commercially insured patients. Net price was then calculated using the same methodology as outlined for the 1986 to 1992 data.

[18] For a critical overview of the 'acute care inpatient' product market definition used in hospital merger investigations, see Sacher and Silvia [1998].

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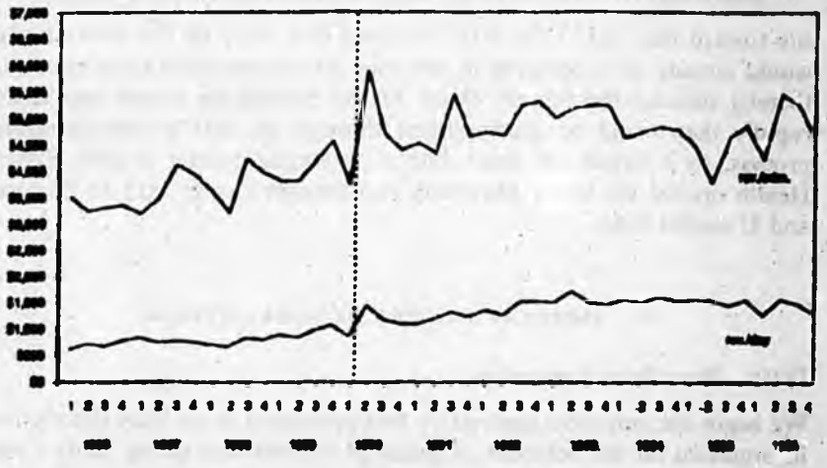


Figure 1
Quarterly Real Price per Admission and per Inpatient Day Dominican Hospital

It should be noted that the price series in Figure 1 does not include information on Community's prices. Normally, we would like to assess the competitive effects of a merger by examining the pre- and post-merger prices of both transaction partners. Unfortunately, that approach is not feasible here because Community was converted to a nursing home/rehab center shortly after the acquisition, and no post-transaction price data are available for it.[19] We have concluded, therefore, that the best available test of the impact of removing this competitive constraint on Dominican's pricing discretion is obtained from comparing Dominican's pre- and post-merger prices; accordingly, the regression results reported in Table III below are based on this comparison. However, to assess the robustness of these results, we also carried out all of regression analyses presented in Table III using (pre-merger) dependent and explanatory variables redefined as weighted averages of the values for Dominican and Community. Our principal findings are robust to this modification.[20]

Figures 1 and 2 depict the behavior of per-day and per-admission prices at Dominican and Watsonville hospitals for the entire sample period. The dashed vertical line indicates the quarter in which the merger occurred. Visual inspection of these series suggests that while there was an upward trend in real prices predating the transaction, prices did increase

[19] The conversion was completed by August 1990. OSHPD ceased reporting separate data for Community after the 1st quarter of 1990.

[20] We experimented with weights based on patient days, patient discharges, and inpatient revenue. All produced essentially the same results. The results reported at the *JIE* Editorial website are derived using inpatient revenue weights.

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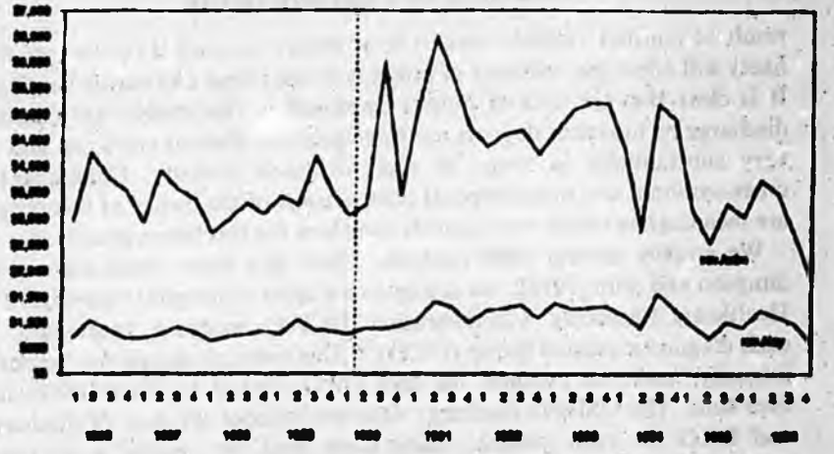


Figure 2
Quarterly Real Price per Admission and per Inpatient Day Watsonville Hospital

in the transaction's aftermath. This assessment is supported by the regression results reported in column (a) of Tables III and IV. Here we present simple regressions of price (real net revenue per admission) on a merger dummy variable (merge) and a time trend (time and time-squared).[21] These regressions suggest a substantial post-merger price increase at both Dominican and Watsonville, on the order of $700 and $1,800 respectively, even when the time trend is controlled for explicitly. We reject the null hypothesis of no merger effect at all conventional significance levels.

While the results contained in Tables III and IV are consistent with a merger-induced increase in price, obviously the simple specification on which they are based will fail to control for many of exogenous determinants of equilibrium prices (except to the extent that they follow a linear-quadratic time trend). If these omitted factors are correlated with merge we will improperly impute their effect to the merger. Similar to Schumann *et al.* (1992, 1997), we next attempt to estimate a more fully specified reduced form price equation.

IV(ii). *Reduced Form Price Equations*

To ensure that the observed price effect of the merger is not merely the

[21] As noted previously, all of the equations reported in the paper also have been estimated with the dependent variable computed on a per-inpatient day basis. In the fully specified version of the price equations, we find that the statistical significance of the coefficient on merge falls in the Dominican equation ($p = 0.18$), but increases in the Watsonville equation ($p = 0.07$).

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result of omitted variable bias, it is necessary to control for factors that likely will affect the behavior of prices both over time and across hospitals. It is clear that the unit of output employed in this study—an inpatient discharge or inpatient day—is nonhomogeneous. Patient stays can and do vary substantially in terms of their resource intensity. Consequently, cross-sectional and intertemporal comparisons of the 'price' of this output are meaningless unless one controls somehow for this heterogeneity.

We employ several such controls. First, like other researchers (e.g., Simpson and Shin [1998]), we construct an index of hospital 'casemix.' The Healthcare Financing Administration (HCFA) assigns a 'caseweight' to each diagnostic related group (DRG).[22] This index measures the 'resource intensity,' used, on average, for each DRG relative to other DRGs and over time. The OSHPD discharge data set includes the date of discharge and DRG for each patient. Using these data, we created a quarterly casemix indicator for each hospital used in the empirical analysis. This was done as follows. Each non-Medicare/non-Medicaid discharge at each hospital for each quarter was weighted using the HCFA caseweight index for the relevant DRG. The weighted discharges were then summed and divided by the total number of discharges for each quarter at each hospital to obtain the casemix index.

As a further control for discharge heterogeneity, we also include the average length-of-stay for privately insured patients. The rationale for including this measure is straightforward—each additional day of hospitalization requires the consumption of additional labor and material resources. One cannot compare the price of a discharge across different time periods, or across different hospitals, unless one controls for variations in length-of-stay.

Equilibrium hospital prices also will be affected by exogenous changes in factor prices. We include two variables to control for these shifts. First, HCFA computes a wage index for all urban areas (a county or set of counties) based on the salaries and wages of various health care workers in the relevant locale. This index is used to adjust hospital payments under the Prospective Payment System (PPS) for Medicare. As an additional control variable, we include the BLS Producer Price Index for surgical and medical instruments and apparatus.

It is well-established empirically that the growth of managed care institutions (e.g., HMCs, PPOs) has facilitated more intense price competition among hospitals (e.g., Dranove, Shanley, and White [1993]; Kralewski *et al.* [1992]), as well as greater productive efficiency. Consequently, other things equal, we would expect to observe lower prices

[22] DRGs refer to a system of classifying patients based on medical diagnoses and surgical procedures. Originating at Yale University during the 1970s, the DRG system has been widely adopted by payers and providers as a way of classifying patients.

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in markets where selective contracting by managed care organizations is more prevalent. Ideally, we would like to utilize some measure of the market share of managed care institutions in the relevant market. Unfortunately, such data are not readily available. As a proxy, we calculate for each hospital the percentage of total discharges for which the expected payment source is an HMO or other prepaid health plan.[23]

Similar to other empirical studies of hospital mergers (e.g., Lynk [1995], Simpson and Shin [1998]), we include a number of other variables to control for exogenous demand- and cost-side variation. These consist of per capita income, the county-level unemployment rate, county population density, share of admissions covered by Medicare, share of admissions covered by MediCal, and the Producer Price Index for medical and surgical equipment.

Last, we also control for the effects of the October 1989 northern California earthquake, which may have reduced (exogenously) Watsonville's productive capacity, leading to higher prices for reasons unrelated to the Dominican transaction. To capture the competitive effects of this event, we create a dummy variable (quake) equal to 1 for the 4th quarter of 1989 and all subsequent periods, and 0 otherwise. We also include a dummy variable (entry) indicating the entry of the small (21 bed) Sutter hospital in 1996.

We note that the earthquake dummy variable is potentially problematic for us, since it is highly collinear with the merger dummy. Essentially, there are only two quarters of data (1989:Q4–1990:Q1) that differentiate these two variables. This may make it difficult to estimate the respective effects of these two events on price with any precision.[24] That said, there are reasons to doubt that the quake actually had an economically significant impact on Watsonville's productive capacity. Whether measured by total patient days or total discharges, the OSHPAD data suggest that Watsonville's output actually increased in the aftermath of the quake.[25]

Column (b) of Tables III and IV presents the reduced form price regressions for Dominican and Watsonville, respectively. In the case of

[23] We recognize that this managed care index quite plausibly is an endogenous variable jointly determined with our price variable; as a consequence, its inclusion could induce simultaneous equations bias in our estimated coefficients. Accordingly, we estimate our equations both with and without this variable. None of our results are sensitive to this change in specification. These results are reported in full at the *JIE* Editorial website.

[24] We note, however, that in the several of the Watsonville regressions, the coefficients on both merge and quake are individually significant, suggesting that there is sufficient variation in the sample to accurately estimate both parameters.

[25] A regression of total patient days against a time trend and the quake dummy yields a coefficient on quake of 803.51 (s.e. = 480.65). A similar regression using total discharges yields a coefficient (standard error) on quake equal to 53.18 (182.24) The full regression results are available at the *JIE* Editorial website.

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Dominican, adding these additional explanatory factors to the reduced form price equations leaves the coefficient on merge essentially unchanged (it actually increases slightly, from $696/admission to $749/admission), but it does increase the standard error of the estimate, from $169 to $474. The corresponding t statistic (1.61) leads one to reject the null hypothesis of no merger price effect at the $p = 0.12$ significance level. For Watsonville,

TABLE I
VARIABLE DEFINITIONS

Variable Name	Description
rprice_d	real net revenue per private admission, Dominican Hospital
rprice_w	real net revenue per private admission, Watsonville Hospital
rprice_p	real net revenue per private admission, peer group hospitals
rpday_d	real net revenue per private day, Dominican Hospital
rpday_w	real net revenue per private day, Watsonville Hospital
rpday_p	real net revenue per private day, peer group hospitals
expadm_d	real expense per admission, Dominican
expadm_w	real expense per admission, Watsonville
expadm_p	real expense per admission, peer group hospitals
expday_d	real expense per inpatient day, Dominican
expday_w	real expense per inpatient day, Watsonville
expday_p	real expense per inpatient day, peer group hospitals
length-of-stay_d	average length-of-stay, Dominican Hospital
length-of-stay_w	average length-of-stay, Watsonville Hospital
length-of-stay_p	average length-of-stay, peer group hospitals
medi-Cal share_d	share of admissions MediCal, Dominican Hospital
medi-Cal share_w	share of admissions MediCal, Watsonville Hospital
medi-Cal share_p	share of admissions MediCal, peer group hospitals
medicare share_d	share of admissions Medicare, Dominican Hospital
medicare share_w	share of admissions Medicare, Watsonville Hospital
medicare share_p	share of admissions Medicare, peer group hospitals
casemix_d	casemix index, Dominican
casemix_w	casemix index, Watsonville
casemix_p	casemix index, peer group hospitals
popdensity_p	population density, peer group counties
popdensity_s	population density, Santa Cruz County
hmo_d	share of admissions HMO insured, Dominican
hmo_w	share of admissions HMO insured, Watsonville
hmo_p	share of admissions HMO insured, peer group
income_s	real per capita income, Santa Cruz County
income_p	real per capita income, peer group counties
ppi_med	producer price index, medical and surgical instruments
unemploy_p	unemployment rate, peer group counties
unemploy_s	unemployment rate, Santa Cruz County
wage_d	HCFA wage index, Dominican
wage_w	HCFA wage index, Watsonville
wage_p	HCFA wage index, peer group
quake	= 1 for 4th quarter 1989 and after, 0 otherwise
merge	= 1 for 2nd quarter 1990 and after, 0 otherwise
entry	= 1 for 2nd quarter 1996 and after, 0 otherwise
time	time trend
timesquared	time trend squared

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estimating the price effect of the merger using the expanded set of regressors reduces the estimated merger effect from $1,843 per admission to $496 per admission. In contrast to Dominican equation, the standard error on the merger coefficient falls with the addition of these regressors to the equation. In this specification, we reject the null hypothesis of no merger effect at the $p = 0.10$ significance level.

TABLE II
DESCRIPTIVE STATISTICS

Variable Name	Mean	Minimum	Maximum
rprice_d	4434.55	3212.89	5882.0
rprice_w	3897.98	1794.32	6490.128
rprice_p	5088.39	3526.29	6288.39
rpday_d	1192.75	623.53	1730.41
rpday_w	994.16	593.75	1566.64
rpday_p	1342.72	783.33	1626.55
expadm_d	4118.93	3212.4	4986.1
expadm_w	3343.72	2582.8	3969.6
expadm_p	4038.26	3185.02	4628.92
expday_d	719.92	497.07	962.92
expday_w	756.47	581.91	1064.58
expday_p	810.87	554.70	1116.33
length-of-stay_d	4.01	2.71	5.63
length-of-stay_w	3.99	2.71	6.79
length-of-stay_p	4.28	3.53	4.88
medi-Cal share_d	0.14	0.051	0.17
medi-Cal share_w	0.29	0.10	0.48
medi-Cal share_p	0.21	0.17	0.25
medicare share_d	0.39	0.33	0.44
medicare share_w	0.31	0.22	0.48
medicare share_p	0.39	0.36	0.42
casemix_d	0.85	0.75	1.04
casemix_w	0.76	0.67	0.87
casemix_p	0.94	0.84	1.06
popdensity_p	88.55	78.69	95.69
popdensity_s	516.96	486.10	539.57
hmo_d	0.25	0	0.50
hmo_w	0.06	0	0.25
hmo_p	0.13	0.05	0.23
income_s	16104.97	14464.69	17700.51
income_p	13214.04	12892.70	13504.33
ppi_med	121.19	107.27	131.27
unemploy_p	10.46	8.02	14.23
unemploy_s	8.35	5.37	13.83
wage_d	1.22	0.97	1.42
wage_w	1.20	0.97	1.39
wage_p	1.16	1.12	1.23
quake	0.659	0	1
merge	0.63	0	1
entry	0.11	0	1
time	22.5	1	44
timesquared	667.5	1	1936.0

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TABLE III
DOMINICAN HOSPITAL PRICE AND EXPENSE REGRESSIONS
(STANDARD ERRORS* IN PARENTHESES)
Quarterly Data, 1986–96

	net rev./ admission (a)	net rev./ admission (b)	net rev./ admission (difference) (c)	exp./ admission (difference) (d)
merger	696.50‡ (169.31)	749.68 (474.71)	1005.49§ (506.49)	172.74 (139.75)
income		−0.30† (0.12)	−0.16 (0.22)	−0.27‡ (0.07)
popdensity		−5.45 (25.99)	29.86 (34.57)	4.36 (8.45)
managed		−72.30† (31.26)	−36.61 (55.09)	16.61 (31.19)
length-of-stay_d		486.26† (177.77)	488.45† (178.71)	39.81 (65.81)
beds_d		−683.83 (1021.08)	−868.32 (1485.21)	229.97 (652.09)
casemix_d		−1609.86 (1793.83)	1628.76 (1355.69)	−857.21 (908.89)
wage_d		−177.02 (390.12)	−603.42 (905.70)	−616.17† (297.87)
ppi_med		71.25 (70.36)	94.55 (87.17)	−34.73 (38.73)
medicare share_d		3805.44 (2623.12)	5191.34 (3122.95)	−1409.13 (1847.34)
medi-Cal share_d		1076.23 (3632.58)	4752.39 (3579.07)	1581.58 (1062.95)
time	68.60‡ (14.48)	31.19 (88.26)	−170.48 (109.39)	−10.24 (38.01)
timesquared	−1.18‡ (0.25)	−0.54 (1.89)	1.44 (0.96)	0.75† (0.34)
quota		263.89 (290.56)	207.52 (302.42)	407.36‡ (143.69)
entry		634.83† (247.84)	480.23† (219.56)	334.38† (167.97)
intercept	3241.67‡ (120.26)	5118.79 (14136.84)	−21598.48 (19087.51)	2540.66 (5076.65)

*Newey-West heteroskedasticity and autocorrelation consistent standard errors (lag length = 4)
†significant at $p < 0.05$
‡significant at $p < 0.01$
§significant at $p < 0.10$.

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TABLE IV
WATERVILLE HOSPITAL PRICE AND HERFINDAHL REGRESSIONS
(STANDARD ERRORS* IN PARENTHESES)
Quarterly Data, 1986–96

	net rev./ admission (a)	net rev./ admission (b)	net rev./ admission (difference) (c)	exp./ admission (difference) (d)
merge	1843.47‡ (423.58)	495.92§ (287.98)	671.83§ (399.48)	79.27 (176.02)
income		−0.54‡ (−0.15)	−0.18 (0.21)	−0.22† (0.09)
popdensity		−103.17‡ (22.03)	−51.67 (40.76)	−38.51† (17.75)
unemploy		0.59 (52.02)	77.21 (90.65)	70.60 (45.63)
length-of-stay_w		765.42‡ (170.76)	527.40† (221.85)	388.64‡ (98.50)
hmo_w		−2681.78 (2922.64)	−834.28 (2823.67)	831.62 (1395.01)
casemix_w		7281.31‡ (1655.52)	7529.36† (3318.51)	−676.27 (918.56)
wage_w		−554.65 (1090.64)	−666.00 (1780.47)	178.95 (616.52)
ppi_med		290.81† (118.51)	285.35† (123.90)	81.73 (71.53)
medicare share_w		952.24 (5536.11)	6768.92 (5999.19)	2113.03 (1868.28)
medi-Cal share_w		−3653.65§ (2043.66)	−1989.69 (2238.57)	−1723.45† (688.39)
time	49.74 (33.93)	102.91 (82.25)	−185.62§ (109.71)	−33.61 (45.63)
timesquared	−2.32‡ (0.59)	−2.42§ (1.28)	0.91 (1.40)	0.33 (0.63)
quake		−485.24§ (266.57)	−754.18† (281.97)	−472.39‡ (139.17)
entry		185.66 (404.22)	446.83 (426.99)	−46.91 (121.96)
intercept	3199.53 (304.76)	22994.86 (14053.78)	−7145.13 (19614.65)	7779.72 (6958.94)

* Newey-West heteroskedasticity and autocorrelation consistent standard errors (lag length = 4)
† significant at $p < 0.05$
‡ significant at $p < 0.01$
§ significant at $p < 0.10$.

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IV(iii). *Reduced Form Price Estimates with 'Peer Group' Controls*

Although we have attempted to specify the reduced form price equation as fully as possible, it is questionable whether this specification fully captures all of the exogenous factors that might affect the equilibrium prices of the merged entity and its competitors.[26] To better capture the effects of these factors, and thus estimate more precisely the equilibrium impact of the merger, we incorporate into our empirical approach elements of the Barton and Sherman [1984] and Kim and Singal [1993] merger studies. These studies analyzed movements in the price of the product affected by the merger, conditional on the price of a substitute product believed to have faced similar demand and cost conditions, but which is unaffected by the merger. By so doing, they controlled for otherwise unobserved demand and cost factors, unrelated to the merger, that might influence intertemporal price behavior at the merging entities.

The State of California has undertaken two studies to categorize hospitals into 'peer groups' for purposes of setting Medi-Cal reimbursement levels, the most recent in 1991 (Department of Health Services, [1991]). These studies form the basis for the construction of the control group used here. The peer grouping method used by the State of California first placed specialty, teaching, and prepaid hospitals in their own separate peer groups. The study then used 'cluster' analysis to group rural hospitals and other 'unusual' hospitals (*see* State of California [1991], § 5). After the latter were classified into these peer groups, only urban short term facilities remained. These facilities were then subdivided into peer groups on the basis of licensed bed size. In the 1982 study, Dominican Santa Cruz and Community Hospital of Santa Cruz were placed in the 'moderately-sized' urban category, while Watsonville was placed in the 'small-urban' hospital peer group. In the 1991 study, Dominican Santa Cruz was placed in the 'medium-sized urban' hospital peer group, which consisted of all hospitals not elsewhere classified with between 170 and 270 licensed beds. Watsonville was placed in the 'moderately small- sized' urban hospital peer group, which consisted of all hospitals not elsewhere classified with between 95 and 170 licensed beds.

We used the following procedure to establish a control group for the current study. First, to ensure that peer hospitals were located in markets as similar as possible to the Santa Cruz market, hospitals located in counties that were part of very large Primary Metropolitan Statistical Areas (PMSAs) were eliminated. This eliminated hospitals located in the following counties: Los Angeles, Orange, Ventura, Riverside, San Bernardino, San Diego, San Francisco, Alameda, Contra Costa, Marin,

[26] Several of the control variables (income, popdensity, unemploy, hmo and wage) vary only on an annual, not quarterly, basis.

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San Mateo and Santa Clara. The competitive environment in such large urbanized areas likely is very different from that found in the less urbanized area of Santa Cruz.

Next, the peer group was restricted to those hospitals that were placed in any of the short term urban hospital peer groups in the 1991 California study, and were licensed with between 100 and 300 beds in that year. While somewhat arbitrary, these licensed bed cut-offs would appear to limit the sample to hospitals reasonably comparable to the hospitals in Santa Cruz. This left 41 potential peer group hospitals. We next eliminated those hospitals in this group that were not in the same bedsize category, and/or that did not fall under one of the urban hospital groupings in the 1982 California Peer Group survey. This left 33 potential peer group hospitals. Eight more hospitals were eliminated because (according to the 1996 *AHA Guide*) they did not fall into the appropriate bedsize category. We then eliminated all hospitals that had themselves been involved in a horizontal acquisition as reported in the OSHPD Hospital History Listing database, or were located in a county where a horizontal merger had occurred during the sample period. This group of 16 remaining hospitals constitutes our peer group (*see* Appendix A).

Column (c) of Tables III and IV presents estimates of the reduced form price regressions incorporating the peer group controls. In these equations the dependent and explanatory variables have been redefined as the difference between the own- and peer group value (e.g., in the Dominican equation, the dependent variable equals the Dominican price minus the (mean) peer group price). The results from this specification continue to suggest a fairly large price effect from the transaction ($1,005/admission in the case of Dominican; $672/admission in the case of Watsonville). These estimates are statistically significant at the $p = 0.06$ and $p = 0.10$ levels, respectively.

Many of the other coefficients in this equation have the expected sign, but are not always statistically significant. The coefficient on average length-of-stay (alos_d and alos_w) is positive in both equations, and significant at the $p = 0.02$ level. The medical equipment price index is positive in both equations, as expected, but significant at conventional levels only in the Watsonville equation. Similarly, the estimated parameter on the casemix index is positive and significant only in the Watsonville equation. The HMO share variable is negatively related to price in both equations, as one would expect, but is never significant.

We also observe an interesting pattern of results on the two event variables, quit ce and entry. In both equations, the coefficient on entry is large and positive; in the case of Dominican, we can reject the null of a zero coefficient at the $p = 0.04$ significance level. Obviously, this is somewhat counterintuitive; one possible explanation is that the entry of Sutter induced Dominican to increase its quality, leading to higher prices

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and higher unit costs. This possibility receives some support from the expense regressions reported in column (d), which show that Dominican's expenses per admission increased by about $263 ($p = 0.08$) when Sutter entered the market. However, the results for the Watsonville equation do not support this hypothesis.

The pattern of coefficients on quake (positive in the Dominican price equation, negative in the Watsonville price equation) can be potentially rationalized as an exogenous quality reduction at Watsonville that allowed Dominican to raise its price. The quake coefficient is not significant in the Dominican equation, however, though it is in the Watsonville equation ($p = 0.06$).

V. ALTERNATIVE EXPLANATIONS FOR THE POST-MERGER PRICE INCREASE

While the empirical results presented in Tables III and IV suggest a post-merger price increase—with the evidence strongest in the case of the merged entity, Dominican—our inability to observe and measure quality perfectly means that we cannot rule out the possibility that the price increases reflect improvements in quality, rather than increased price-cost markups with unchanged (or even diminished) quality levels. The evidence on this possibility is mixed. We observe first that the parties to the acquisition made no such claims in defense of the transaction. If significant quality improvements resulted from the transaction, they were not foreseen by the parties at the time of transaction. Rather, the parties claimed that the efficiencies from the transaction would derive from the realization of scale-related production efficiencies.[27] To the extent that such scale economies were realized, we would expect prices to fall, other things held constant.

It is perhaps conceivable that consolidation of particular services at Dominican could lead to volume-related quality increases—for example, because clinical outcomes for some procedures improve as the procedure is performed with higher frequency at a particular location.[28] Then, Dominican might be able to capture some or all of the value of this quality increase in the form of higher prices.

The problem with this explanation is that it fails to explain the post-merger increase in price at Watsonville Hospital. If the elimination of Community Hospital as a provider of the services in question leads to higher (quality-unadjusted) prices at Dominican because of the efficiencies

[27] See Statement of Commissioner Yao. Dominican claimed that Community Hospital was inefficiently small, and that efficiencies could therefore be realized by converting it to a skilled nursing/rehabilitation facility, and channeling its patients to Dominican.

[28] For a large number of clinical procedures there is empirical evidence that outcomes improve with patient volume. See, e.g., Begg *et al.* [1998] and Selby *et al.* [1996].

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described in the preceding paragraph, Watsonville would either have to (1) reduce its price (assuming that its quality remained unchanged); or (2) match Dominican's quality increase. If Watsonville captured some of the patient flow that otherwise would have patronized Community, then it too might be able to realize volume-related quality increases. But if this occurred, then it is unclear why prices would rise unless the transaction also had adverse competitive effects.[29] In a competitive market, prices are determined by cost, not demand (demand determines the equilibrium quantity, but price will be determined by marginal cost). If the quality of certain services increases at both hospitals (but costs remain unchanged), then there will be a market-wide increase in demand for the service, leading to an increase in the total quantity sold. But if marginal costs are constant, and prices are determined competitively, the price at which this service is sold would not change. If prices increase, it suggests that the transaction has increased market power, even if it simultaneously yielded efficiencies.

It perhaps is conceivable that the merger led to other types of quality increases at both Dominican and Watsonville that are not related to volume, but which manifest themselves in greater resource use per patient. If so, we might observe a post-merger increase in expenses per admission or expenses per day—hence prices—at both hospitals, other things held constant. We carry out two tests of this hypothesis. First, we construct dependent variables equal to the difference in per admission expenses between Dominican (Watsonville) and the peer group, and regress this difference against the same explanatory variables employed in the column (c) regressions. Column (d) of Tables III and IV reports the results of these regressions. The results of this test do not support the hypothesis of higher post-merger quality. In the Dominican equation, the coefficient on merge suggests only a small increase in per-admission expenses; we cannot reject the hypothesis that there was no post-merger increase in per-admission expenses. Similarly, in the Watsonville expense regressions we find only a small ($79) post-merger increase in per-admission expenses; as with Dominican, we cannot reject the hypothesis that the true coefficient on merge equals zero.

We conduct a second test of the efficiency hypothesis by examining data on patient flows. If the transaction improved the quality of hospital care provided in Santa Cruz County, relative to that provided in hospitals outside the county, we would expect to observe (*ceteris paribus*) an increase in the proportion of Santa Cruz County residents who seek hospital care within Santa Cruz county. To test the efficiency hypothesis,

[29] The other possibility is that marginal cost increases with output. This possibility is difficult to reconcile with the efficiency claims actually put forth by the parties; i.e., that the merger allowed the merged entity to enjoy scale-related reductions in unit cost.

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1. Hospitals purport that Oklahoma hospitals went out of business due to lack of protection from CON. What are the real reasons that they went out of business, what was the time frame, and what true impact did CON reform have on this situation (if any)?

Numerous academic and government sponsored studies have indicated that there are many factors that account for hospital closures. A 1989 Executive Summary by the U.S. Inspector General of Health and Human Services examined hospital closings on a national basis found there was no single reason for hospital closures but rather a number of conditions which gradually weakened the financial condition of the hospital.[1] Rather, the study found underlying commonalties in closed hospitals included: (1) declining revenue due to fewer admissions, lower third party reimbursement, more uncompensated care, and (2) rising costs due to increasing demand for new technology, skilled personnel, and facility maintenance, renovation, or replacement.[2]

According to a study at Northwestern University by Dr. R.C. Lindrooth, Ph.D, urban hospitals go out of business when there is a surplus of beds in the area or when they treat a large percentage of Medicaid patients, which may lead to uncompensated care.[3] They also tend to be inefficient, and when they close, the overall efficiency of the market increases. Rural hospitals go out of business when they are less diversified. Successful hospitals provide a large proportion of outpatient visits and surgeries while using the newest technology. The Lindrooth study also found that hospital mergers that result in the closing of one facility have more cost savings than other types of mergers. The study concludes that in markets with low occupancy rates and where patient access to care is not a problem; hospitals should be allowed to close.[4]

A 2000 report by the U.S. Office of Inspector General within Health and Human Services of 1998 U.S. hospital closings found similar reasons as outlined above. For both rural and urban hospitals, occupancy rates were lower than the national average, Medicare utilization was lower than the national average, and Medicaid utilization was higher. Closed hospitals also cited outdated equipment as a contributing factor to their demise.[5]

Some hospitals within Oklahoma expected to be (and subsequently have been) forced into closure due to a negative cash-flow as a result of rising liability and malpractice insurance rates.[6] Rural Oklahoma is faced with a unique set of issues which may have led to hospital closures. Many physicians in Oklahoma are located within the major cities partially due, in part, to city

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[1] "Hospital Closure: 1987" Richard P. Kusserow, Inspector General, U.S. Department of Health and Human Services, May 1989, p. 7.

[22] "Hospital Closure: 1987" Richard P. Kusserow, Inspector General, U.S. Department of Health and Human Services, May 1989, p. i-ii.

[3] "Cause and Effect of Hospital Distress and Closure," Richard C. Lindrooth, Northwestern University, AHRG Grant HS10730.

[4] "Cause and Effect of Hospital Distress and Closure," Richard C. Lindrooth, Northwestern University. AHRG Grant HS10730.

[5] "Hospital Closures: 1998," Office of Inspector General, July 2000, p. 2-9.

[6] Edmond Lawmaker: Hospital Closing Reflects Need for Lawsuit Reform," available at http://www.lsb.state.ok.us/HOUSE/news7705.html.

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hospitals which purchase rural practices.[7] As an adequate supply of physicians are vital to the operation of a hospital, some rural Oklahoma hospitals have faced closure due to the shortage pf physician manpower.[8]

What studies have shown that it is especially important for rural areas to have a viable health sector to promote growth in existing markets and to entice new businesses to the area?[9] Additionally, a 2003 study of Atoka County, Oklahoma determined that the hospital is usually the largest employer of non-farm workers, as demonstrated.[10] The health sector employed ten percent (10%) of the non-farm workforce, and when adjusted for the number of new jobs this employment created, the impact was approximately twenty percent (20%).[11] When the health care delivery system (hospitals) fails, the overall economy suffers. It is therefore important to allow competition among hospitals, which might result in the closing of poorer performing hospitals, thereby allowing successful ones to thrive and maintain the local economy.

A 2002 study by Project Hope of the Center for Health Affairs reported (Streisand et al.) no dramatic ill economic effects of rural hospital closings in Appalachia.[12] Recognizing the inconsistency with other study findings, they saw population and employment growth similar to the average in other Appalachia areas among communities whose hospital had closed, although employment did decline over the long-term in these communities. They reported that eight (8) out of ten (10) communities whose only hospital had closed between 1986 and 1996, had more jobs four (4) years after closure than two (2) years prior. However, hospitals only accounted for about one percent (1%) of total employment in the counties studied. Reasons for hospital closings included being a smaller hospital with less money or having nearby competitors. Closings, though, allowed money to be reallocated for improvement of long-term care services and ambulance services (See attached exhibit 1).[13]

The reasons for the Oklahoma hospitals closing include consolidation and all factors above. There is no statistically valid evidence on record to support a condition of causation between the repeal of Certificate of Need in Oklahoma to a reasonable certainty as the proximate cause of market competition resulting from the relaxation of Certificate of Need regulation related to hospital development in Oklahoma.

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[7] "Commission Puts Physicians in Rural Areas," Manny Gamallo, Tulsa World, May 13, 1996, p. A9.
[8] "Commission Puts Physicians in Rural Areas," Manny Gamallo, Tulsa World, May 13, 1996, p. A9.
[9] "Economic importance of Health-care Sector in Rural Economy," G.A. Doeksen and V. Schott, International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy, Vol. 3 (online), (June 10, 2003), pp. 1-6.
[10] "Economic importance of Health-care Sector in Rural Economy," G.A. Doeksen and V. Schott, International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy, Vol. 3 (online), (June 10, 2003), pp. 1-6.
[11] "Economic importance of Health-care Sector in Rural Economy," G.A. Doeksen and V. Schott, International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy, Vol. 3 (online), (June 10, 2003), pp. 1-6.
[12] "An Analysis of the Financial Conditions of Health Care Institutions in the Appalachian Region and their Economic Impacts," Jeffrey Stensland, Curt Mueller, Janet Sutton, Project HOPE, Center for Health Affairs, December 2002, pp. i-66.
[13] "An Analysis of the Financial Conditions of Health Care Institutions in the Appalachian Region and their Economic Impacts," Jeffrey Stensland, Curt Mueller, Janet Sutton, Project HOPE, Center for Health Affairs, December 2002, pp. i-66.

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2. Are there data from states/agencies on the cost and benefit ratios from repealing CON? How much money, if any, would be saved by repealing CON?

Several academic studies have investigated the costs and benefits of Certificates of Need. The Alabama Policy Institute's research examined two studies.[14]. The first study by Duke University Professors Christopher Conover and Frank Sloan showed "no decrease in per capita healthcare spending attributable to CON."[15] The other, older study "found that CON was responsible for a 13.6 percent increase in per capita spending on personal healthcare services."[16] The Alabama Policy Institute also examined a wide variety of studies done by the U. S. Federal Trade Commission and reiterated their conclusion that "there is considerable evidence that [CON programs] can actually drive up prices...".[17]

A report about healthcare in Maine found that "regulatory activities (e.g., government protocols related to licensure, Certificate of Need), were noted by payers as well as providers as contributing to higher costs."[18] The report by the Department of Justice and the Federal Trade Commission (quoted in the Alabama Policy Institute study) elaborates its claim that CON program drive up prices by stating that CON creates barriers to entry.[19]

3. Summary of CON pros/cons.
CON RESEARCH CONSENSUS

The beneficial aspects of market competition in healthcare are significantly obstructed from controlling costs, providing patient access and choice, and improving quality, by a number of systemic barriers including the continued imposition of CON laws. These barriers to competition limit the types of innovation and technological advancements that create inefficiencies in other industries, ultimately resulting in higher costs and lower quality care. Specific aspects of the challenges related to CON are examined below in greater detail.

a. Theoretical Rationale for Eliminating CON

CON regulations, by reducing competition and consumer choice, inhibit market mechanisms that are vital components of the current healthcare system. Furthermore, a review of the literature clearly establishes that CON regulations have not achieved the forecasted reduction of overall healthcare costs, nor have they improved the quality of healthcare.

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[14] "Certificate of Need Laws: Why It's Time for Repeal" by Dr. Roy Cordato, 2007, p.16-17.
[15] "Certificate of Need Laws: Why It's Time for Repeal" by Dr. Roy Cordato, 2007, p. 17.
[16] "Certificate of Need Laws: Why It's Time for Repeal" by Dr. Roy Cordato, 2007, p. 17.
[17] "Certificate of Need Laws: Why It's Time for Repeal" by Dr. Roy Cordato, 2007, p. 17.
[18] "The Cost of Health Care in Maine" by the Year 2000 Blue Ribbon Commission on Health Care., November, 2000, p. 23.
[19] "Improving Health Care: A Dose of Competition" by the Federal Trade Commission and the Department of Justice, July 2004, ch. 8, pg. 4.

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i. The Certificate of Need Paradox

CON proponents claim that this regulatory mechanism is able to "do a lot with a little". This claim is based on CON's simplistic and low budget review of capital expenditures of those entities applying under the CON process and a comparison of existing and forecasted population, utilization, and occupancy rates based upon arbitrary, capricious, and unfounded comparative criteria that do not at all consider "down-stream costs", patient access, beneficial outcomes, or quality of care. CON laws seek to limit capital expenditures based on the flawed, unsupported, and refuted assumption that limiting infrastructure investment achieves lower overall healthcare costs. CON has been implemented as a clumsy, heavy-handed, "meat-ax" attempt by legislators to control the costs of healthcare by reducing duplication of services, without first determining what constitutes "duplication" or whether duplication raises costs. Many hospitals and other healthcare service providers encourage CON laws because they perpetuate a more predicable competitive environment by limiting competition in favor of the established oligopoly provider. The motives underlying the continued support for CON laws have pronounced implications for public policy, and invite a detailed investigation of the goals, processes, and requirements inherent in CON laws. By deconstructing the CON concept, the paradoxes of its development and continued implementation become apparent.

ii. Market Failure

1. Justification for Governmental Intervention

An essential element in attempting to justify government intervention in the economic, competitive mechanisms of the private market is the claimed need for correction of perceived market failures. Regardless of the prior state of healthcare markets, CON reduces competition and thereby creates or exacerbates market failures, by adding further barriers to market entry for innovative new market entrant competitors. In essence, government regulation thwarts innovation, and, lacking innovation, both U.S. healthcare costs, efficiencies, and quality will not improve. CON serves as a hidden tax, unauthorized by or disclosed to the public, which is falsely justified by unsupported claims by hospitals to avoid competitors so they can maintain higher prices for some services in pursuit of promised cross-subsidization of other services.

iii. Managed Care Cost Controls

Free markets allow purchasers of healthcare services to negotiate for lower costs in the face of the strength and leverage of established, large health system providers. CON laws shelter these established, large healthcare providers from the demands and needs of purchasers and payors regarding cost, quality, access, and patient choice. These desirable aspects of the healthcare market mechanisms may, however, be substantially thwarted by hospital oligopolies under color of CON laws.[20]

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[20] Patrick John McGinley, Beyond Health Care Reform: Reconsidering Certificate Of Need Laws In A "Managed Competition" System. 23 Fla. St U.L. Rev. at 141, 168.

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Integrated Delivery Systems

CON regulations promote the construction of vertically integrated systems, by disfavoring horizontal consolidation.[21] "Attempts by providers to reduce costs, gain efficiencies of size, and position themselves aggressively in the marketplace have resulted in the formation of integrated delivery systems of such providers. However, the CON laws still in existence in 37 states and the District of Columbia actually increase the costs of forming these associations, while at the same time slowing the rate at which the providers are able to react appropriately to changing market circumstances."[22] However, at the same time, CON adds unnecessary costs to the development of these systems. To the extent that horizontal consolidation may allow, in a given market and / or geographic circumstance, for achieving the significant benefits of cost, quality, access, and patient choice, then CON defeats its own stated desired outcome and purpose.

b. Impracticality of CON Legislation

Even, in the hypothetical, it were to be determined that CON regulations were able to control healthcare costs, major revisions would be necessary in order for them to be an effective and valid tool for this type of drastic government intervention into the complex competitive mechanisms of the healthcare market. The process would need to provide a more sophisticated, science-based methodology with objective analysis of valid and pertinent empirical data that reasonably considers the appropriate wider range of public health factors that are considered within the context of a larger public health vision. A comprehensive health planning policy, setting forth and based upon a consensus related to desired objectives is needed in order for any successful design or implementation of CON regulations. Lacking that, CON acts as the subjective enforcer of selective oligopoly interests – the "rule-of-men" not the "rule-of-law".

Eliminates Patient Choice

There is ample evidence in the economic and business literature that, in a market economy, competition can create choices for consumers and raises quality standards as providers compete for patient loyalty. By eliminating competition, whether through the acquisition of physician practices or by utilizing CON to block new, competitive providers, and hospitals undermine the primary system of checks and balances in healthcare – patient choice. When patient choice is constrained or vanishes, control shifts from patients to committees of business executives, hospital administrators, and private organizations that loudly claim to have community health as their primary interest while, at the same time, often demonstrating a contempt for the competition that provides the fundamental aspects and incentives of patient access and choice to allow the public health objectives to be achieved.

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[21] McKinlay, J. B. and Stoeckle, J. D. (1988). Corporatization and the social transformation of doctoring. International Journal of Health Services 18, 191-205.

[22] Braulino Montesino, Anatomy of a Roadblock, Health Systems Review at 30 (1996).

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When patient choice is diminished, decisions about access, quality, and beneficial outcomes become the sole purview of these elite groups. 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 community may be determined to lack a sufficient utilization ratio to allow alternative market entrants. Without ample consideration of access to healthcare services, a patient's right to choose for himself and his family, the methodology utilized by CON laws does not meet the needs of the healthcare community or reflect the interest of the public. Instead CON serves to promote the oligopoly interests of existing, established provider organizations who find competition inconvenient.

Closely correlated to CON laws' dangerous denial of access and patient choice is the barrier to entry posed by these rules. New medical provider entrants, no matter how efficiently and creatively they might contribute to higher healthcare quality, more beneficial patient outcomes, greater patient access and convenience, and lower ***overall*** healthcare costs, face substantial opposition by these established interests, who would utilize CON laws to actively strive to limit competition and thereby deny patient choice.

Overall Healthcare Costs Not Considered

Current CON regulations do not consider the overall costs or the totality of healthcare costs for the state. By focusing on the capital costs, the operational costs are overlooked. Capital investment may, in fact, reduce the overall costs of healthcare provision.

No consideration was given to a comparison of an overall cost of the continued utilization of older technology to the investment in newer technology. For example, a certain piece of medical equipment may be deemed cost-appropriate simply because it falls slightly below the expenditure threshold. At the same time, a different piece of equipment with improved technology which significantly enhances the quality of care; provides a lower operating cost per procedure; and prevents further exacerbation of the patient's medical condition, thereby saving enormous downstream patient treatment costs, is not considered cost-appropriate because the initial investment to attain it is slightly over the application of the artificial, arbitrary and capricious expenditure threshold promulgated by CON laws. In this manner, these laws irrationally defy any semblance of rational economic administration of public health and safety, while at the same time doing absolutely nothing to lower the overall costs of healthcare.

Prevention, Wellness, and Other New Cost Containment Mechanisms

CON regulations are being replaced by new, more effective cost containment strategies such as Medicare's Prospective Payment Systems (PPS), wellness/prevention programs and education, and, in theory, the growth of managed care. The re-evaluation of CON laws leads to the question, "does removing certificate-of-need regulations lead to a surge in health care

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spending?"[23] In December 1996, Pennsylvania's CON program expired due to an unexpected legislative oversight. Although many people feared that this would cause serious problems for healthcare providers in the state, they did not materialize according to local regulators and providers. Market forces and local planning apparently took over.[24] New Jersey has also been cited as a state which did not experience a significant increase in health facilities after relaxing CON standards.[25] Ohio, however, saw growth in the number of non-hospital facilities, particularly ASCs, after eliminating CON.[26]

c. Lack of Data and Inappropriate Methodology

i. Insufficient Data

Policy makers often do not have sufficient relevant or accurate data to guide CON decisions.

ii. Reliability of CON Application Data

Kottle v. Northwest Kidney Centers is a case where information to the CON board was falsified in order to have a new dialysis center turned down. The information helped to stifle competition and allow the current operator to maintain a monopoly although there was a clear need for the facility.[27]

iii. CON Methodology Doesn't Consider All Variables

Often the methodologies employed do not include demographic analyses, epidemiological analyses, market analyses, and forecasting analyses that account for all the relevant co-variables involved. Instead, variables that are dependent are often considered independent for analytical purposes. Utilization for one type of medical equipment often varies depending upon the utilization of other medical equipment devices.

For example, CT scanning equipment and PET scanners are both expensive enough to require CON approval in most states with CON laws. For many types of conditions these different imaging tools are used for the same diagnostic purposes. Therefore greater PET utilization may lower the utilization of CT or MRI and vice versa.

iii. Utilization Measures Don't Consider Population Variations

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[23] Christopher Conover and Frank Sloan, Does removing certificate-of-need regulations lead to a surge in health care spending?, Journal of Health Politics, Policy and Law, Vol. 23 Issue 3 at 455.

[24] "Pennsylvania: Unplanned demise of CON program has not caused upheaval in industry." BNA's Health Law Reporter, Vol. 6, no. 33 (Aug. 14, 1997).

[25] "Opportunity at 'Sunset': Missouri relaxes its certificate of need requirements for ambulatory surgery centers" Missouri Medicine, Vol. 99, no. 2 (Feb. 2002), p. 71.

[26] "Opportunity at 'Sunset': Missouri relaxes its certificate of need requirements for ambulatory surgery centers" Missouri Medicine, Vol. 99, no. 2 (Feb. 2002), p. 71.

[27] Young M. Park, Antitrust: Monopoly of Kidney Dialysis Service—Kottle v. Northwest Kidney Centers, 24 Am. J. L. and Med. at 503, 504 (1998).

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Utilization methods do not account for disease incidence across populations nor do they account for the variation of population subgroups. These spatial patterns of disease are often not included in CON utilization thresholds or units per population "need" methodologies. A wider vision is needed in order to make CON regulations work.

I FINAL THOUGHTS

If the market is not effective in controlling healthcare costs then other means may need to be employed. These may range from socialized national healthcare, as is widely found in Europe and other industrialized nations, to a completely fee-for-service system. On the other hand, managed care was touted by the government as the answer to healthcare cost inflation beginning with the HMO Act of 1973.[28] The term *health maintenance organization* was first coined during this period, referring to a prepaid organization that provided healthcare to voluntarily enrolled members in return for a preset amount of money on a PMPM basis. The HMO Act provided grants and loans for new HMOs and aided the expansion of existing HMOs.[29] It also required employers (with at least 25 employees) to offer two federally qualified HMO plans to their existing healthcare coverage mix.[30]

Managed care did temporarily slow the growth of health insurance premiums. However, controlling costs by limiting utilization, as CON laws also do, has not stopped cost inflation and has lowered healthcare quality. In order to best balance quality and cost, utilization must be controlled to prevent unnecessary care and reimbursement must be structured to provide incentive to providers and facilities to provide adequate level of care including preventative treatments.

I.A Methodology Suggestions

I.A.1 Local Market Utilization Analysis

Any utilization analysis must also consider the context of the neighborhoods serviced by healthcare facilities and equipment. Service area demographic analysis must be considered in order to provide meaning to utilization data. Markets are unique and require different standards dependent on population characteristics. Population projections and demographic analysis of characteristics would enhance the use of utilization data.

I.A.2 The Influence of Market Power

Any appropriate methodology would also investigate market power. Market share can be used to measure the potential monopolistic tendencies of hospitals in a given service area.[31] Healthy

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[28] The Managed Health Care Handbook, 3rd edition, Aspen Publishers, 1996, p. 6.
[29] The Managed Health Care Handbook, 3rd edition, Aspen Publishers, 1996, p. 6.
[30] The Managed Health Care Handbook, 3rd edition, Aspen Publishers, 1996, p. 6.
[31] Greenberg, W. (Dec. 1998). Marshfield Clinic, Physician Networks, and the Exercise of Monopoly Power. Health Services Research 33(5) 1461-1476

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competition gives economic power to patients. In 1990, hospitals in more competitive markets had average costs below those of less competitive markets.[32]

I.A.3 Consideration of Unit Costs

Per capita costs, per day costs, per admissions, and per procedure cost should be used as a more accurate measure of total hospital utilization costs.[33] Cost per Relative Value Unit (RVU) may also provide a more accurate representation of costs.

I.A.4 Costs of Empty Hospital Beds

The costs of empty hospital beds should be linked to the market environment in which the hospital operates.[34] By doing so, variations in cost can be accounted for without resorting to uniform standards that may be inequitable in certain service areas.

I.A.5 Fluctuations in Hospital Occupancy Rates

Simple uses of target occupancy levels are not sufficient in utilization analysis. Any analysis must include aspects of fluctuation in hospital bed utilization over the long term and short term to account for emergency demand.[35]

I.B Data Recommendations

I.B.1 Population and Demographics Data

Population and demographics data utilized in CON analyses also needs careful scrutiny. For example, U.S. Census data for specific census tracts will vary from data at the block group level, which data is often taken from samples and is therefore less reliable. The specific Census geopolitical designated regions for which data is available may not appropriately match the provider catchment or patient service area for which need is being determined.

I.C Alternate Approaches for Governmental Influence on Healthcare Costs

Free market competition independently establishes need for new health facilities, equipment, and services. In an unregulated market, investors in new healthcare infrastructure must conduct their own market research into the local demand for and availability of the proposed health service;

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[32] Zwanziger J, Melnick G, Bamezai A. "California providers adjust to increasing price controls." In *Health Policy Reform: Competition and Controls*. Edited by R. Helms, pp. 241-58. Washington, DC: AEI Press, 1993.

[33] Antel, J. J., Ohsfeldt, R. L. and Becker, E. R. (Aug. 1995). State Regulation and Hospital Costs. The Review of Economics and Statistics 77(3) 416-422

[34] Magnussen, J. and Mobley, L. R. (Nov. 1999). The Impact of Market Environment on Excess Capacity and the Cost of an Empty Hospital Bed. International Journal of the Economics of Business 6(3) 383

[35] Green, L. V. and Nguyen, G. V. (June, 2001). Strategies for Cutting Hospital Beds: The Impact on Patient Service. Health Services Research 36(2) 421

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the sources or payment and their sufficiency for local patients and payors; the existence and capacity of competing and substitute providers and services; as well as, all of the other competitive factors influencing the viability of a new health service business investment.

Competition compels providers to control costs and provide quality service. This competitive system is the basis for cost control in the U.S. economy. CON is an artificial, government imposed barrier to competition rarely seen in the U.S. or outside of the healthcare industry. To switch to a regulated system of cost control in healthcare would require an enormous level of control and coordination far beyond the current small scope of the information gathering and analysis capacity of existing CON programs. Such an effort to switch to a regulated market would be one to which Americans have historically appeared to oppose.

Michael Porter (et al.) wrote in the Harvard Business Review that,

> *"In industry after industry, the underlying dynamic is the same: competition compels companies to deliver increasing value to customers. The fundamental driver of this continuous quality improvement and cost reduction is innovation. Without incentives to sustain innovation in health care, short-term cost savings will soon be overwhelmed by the desire to widen access, the growing health needs of an aging population, and the unwillingness of Americans to settle for anything less 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."*[36]

If the healthcare industry is to achieve a reduction in cost in response to market pressures, then the healthcare market must first create incentives for innovation. The barriers to competition cannot include barriers to innovation as many do now. Healthcare purchasers, managers, and legislators must ensure innovation takes the forefront of any reform, if it is to be effective.

If we are to achieve **value** in healthcare delivery there must be concern about how innovation and competition can achieve the really important considerations - access, quality, beneficial outcomes, appropriate cost and patient choice. The continued imposition of Certificate of Need regulatory policy serves as an impediment for each of these objectives, and acts instead to serve only the desire of oligopoly health systems to avoid the inconvenience of market competition.

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[36] "Making competition in health care work." By Michael Porter, et al. Harvard Business Review, July/Aug. 1994, p. 131.

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on behalf of the
Missouri Health Facilities Review Committee

Thomas R. Piper

Director, Missouri Certificate of Need Program

a presentation to the
Alaska Senate
Health, Education & Social Services Committee
by conference call
Juneau, Alaska
1:30 pm, Friday, February 8, 2008

Topics

CON Today
FTC Testimony
CON Concepts and Issues

Certificate of Need: Protecting Public Interests

Free Market and Competition
Business Health Studies
CON Rationale

Benefits

a Map of the
2007 Relative Scope and Review Thresholds: CON Regulation by State
(a geographic illustration of the CON matrix)



revised September 17, 2007

The CON Matrix of
2007 Relative Scope and Review Thresholds: CON Regulated Services by State

(summarized from 2007 information collected by email directly from Certificate of Need directors – also see related map depicting relative levels of regulation across the United States)

compiled by **Thomas R. Piper**
Missouri CON Program
Jefferson City, MO
573 751 6403
tmarquess@msn.com

Rank (no. of svcs x weight)	Categories	Tally (no. of svcs.)	Reviewability Thresholds: Capital	Mod Eqpt	New Svc	Weight
29.7	Vermont	27	1,000,000	1,000,000	500,000	1.1
28.6	Georgia	26	1,483,083	823,934	any amt	1.1
25.2	West Virginia	28	2,000,000	2,000,000	any amt	0.9
24.0	Maine	24	2,666,198	1,333,099	112,800	1.0
22.5	Connecticut	25	3,000,000	3,000,000	any PET, CT, MR	0.9
22.0	South Carolina	22	2,000,000	600,000	1,000,000	1.0
20.8	North Carolina	26	2,000,000	750,000	0	0.8
18.9	Dist. of Columbia	27	2,500,000	1,500,000	600,000	0.7
18.4	Tennessee	23	2,000,000	1,500,000	any amt	0.8
17.1	Alaska	19	1,150,000	1,150,000	1,150,000	0.9
17.0	Mississippi	17	2,000,000	1,500,000	any amt	1.0
16.8	Kentucky	21	2,380,123	2,380,123	n/a	0.8
16.8	Rhode Island	20	2,000,000	1,000,000	750,000	0.8
15.6	New York	26	3,000,000	3,000,000	any amt	0.6
15.6	Hawaii	26	4,000,000	1,000,000	any amt	0.6
15.2	Michigan	19	2,817,500	any amt	any clinical	0.8
12.6	New Hampshire	12	2,504,754	400,000	any amt	1.0
15.0	Iowa	15	1,500,000	1,500,000	500,000	1.0
14.4	Alabama	24	4,251,780	2,125,890	any amt	0.6
12.0	Missouri	12	1,000,000	1,000,000	1,000,000	1.0
11.9	Washington	17	1,000,000	n/a	any amt	0.7
11.7	New Jersey	13	2,000,000	2,000,000	any amt	0.9
8.4	Arkansas	7	500,000	n/a	n/a	1.2
7.8	Oklahoma	6	500,000	n/a	any beds	1.3
7.2	Delaware	12	5,800,000	5,800,000	n/a	0.6
6.3	Virginia	21	15,000,000	lstd eqpt	lstd svc	0.3
6.3	Montana	7	1,500,000	n/a	150,000	0.9
5.7	Maryland	19	10,000,000	n/a	5,000,000	0.3
5.6	Florida	8	n/a	n/a	n/a	0.7
5.1	Massachusetts	17	13,592,292	1,449,844	any amt	0.3
4.8	Illinois	16	7,818,549	6,809,655	any amt	0.3
4.5	Nevada	9	2,000,000	n/a	n/a	0.5
4.4	Wisconsin	4	1,000,000	600,000	any LTC	1.1
2.4	Oregon	2	anyLTC/hsp	n/a	LTC/hsp	1.2
1.0	Ohio	2	2,000,000	n/a	n/a	0.5
0.4	Nebraska	2	anyLTC/rehab	n/a	n/a	0.2
0.4	Louisiana	2	n/a	n/a	LTC/MR	0.2

broadly defined

Right Hand Rank under validity to volume of items reviewed, NOT intensity of analysis or conclusions which are based on Criteria and Standards and decisions

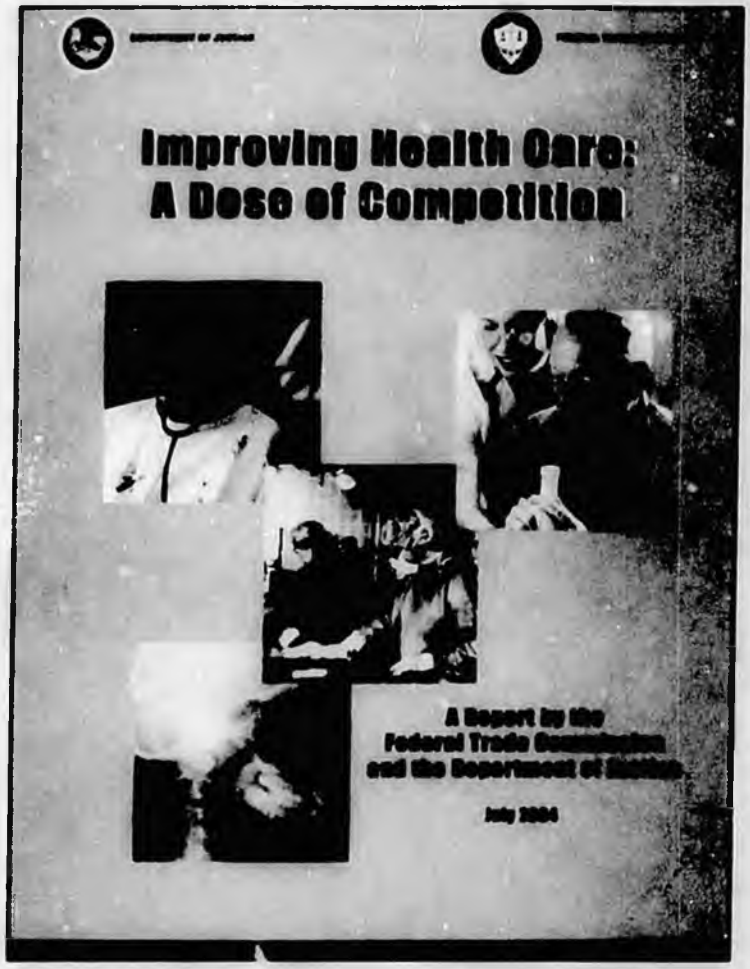
Source: Updated September 17, 2007 using most recent information available

Duration of CON Regulation by State



July 2004 FTC/DOJ Report & AHPA Critique

Improving Health Care: A Dose of Competition



The Federal Trade Commission
&
Certificate of Need Regulation

An AHPA Critique

January 2005

I	Overview	3
II	Context & History	4
III	Nature of the FTC Critique	6
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X	Conclusions	15

American Health Planning Association
. . . pointing it all together

QuickTime™ and a
TIFF (Uncompressed) decompres
are needed to see this picture.

July 2004 FTC/DOJ Report

Intent of the Message

Recommendation 2. States should decrease barriers to entry into provider markets.

a) States with Certificate of Need programs should reconsider whether these programs best serve their citizens' health care needs.

The Agencies *(FTC and DOJ)* 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. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market. As noted earlier, the vast majority of single-specialty hospitals – a new form of competition that may benefit consumers – have opened in states that do not have CON programs. Indeed, there is considerable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns.

b) States should consider adopting the recommendation of the Institute of Medicine to broaden the membership of state licensure boards.

c) States should consider implementing uniform licensing standards or reciprocity compacts to reduce barriers to telemedicine and competition from out-of-state providers who wish to move in-state.

<www.ftc.gov/opa/2004/07/healthcarerpt.htm>

QuickTime™ and
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are needed to see this picture.

July 2004 FTC/DOJ Report

Objective Conclusions

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.

We believe in the importance of community-oriented health services and systems, and **encourage 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.



Marketplace Issues Revealed

- **Capital costs** in healthcare are passed on to the consumers.
- **Competition** in healthcare usually **does not lead to lower charges**:
  - … providers control supply
  - … demand is determined by providers
  - … consumers lack adequate information.
- **Consumers do not** (and usually cannot) **"shop"** for health care, at least, not based on price or quality (usually unavailable).
- **Increased capacity costs** lead to higher delivery charges.
- **Consumers do not pay most of the cost**, and do not really know the true cost of, or charges for, most care (third-party payers do).
- **Providers have few direct incentives** to lower charges/utilization.



CON Concepts
Views of the Critics

- CON focuses mostly on **cost control** by restricting market entry, capital outlays and technical innovation.

- CON looks largely at the **geographic aspects** of access rather than broader social and system access questions.

- CON does not assume a role in, or have a concern with, **quality** in health services.

- CON is generally unaware of the uses and limits of **market forces** in health services delivery.

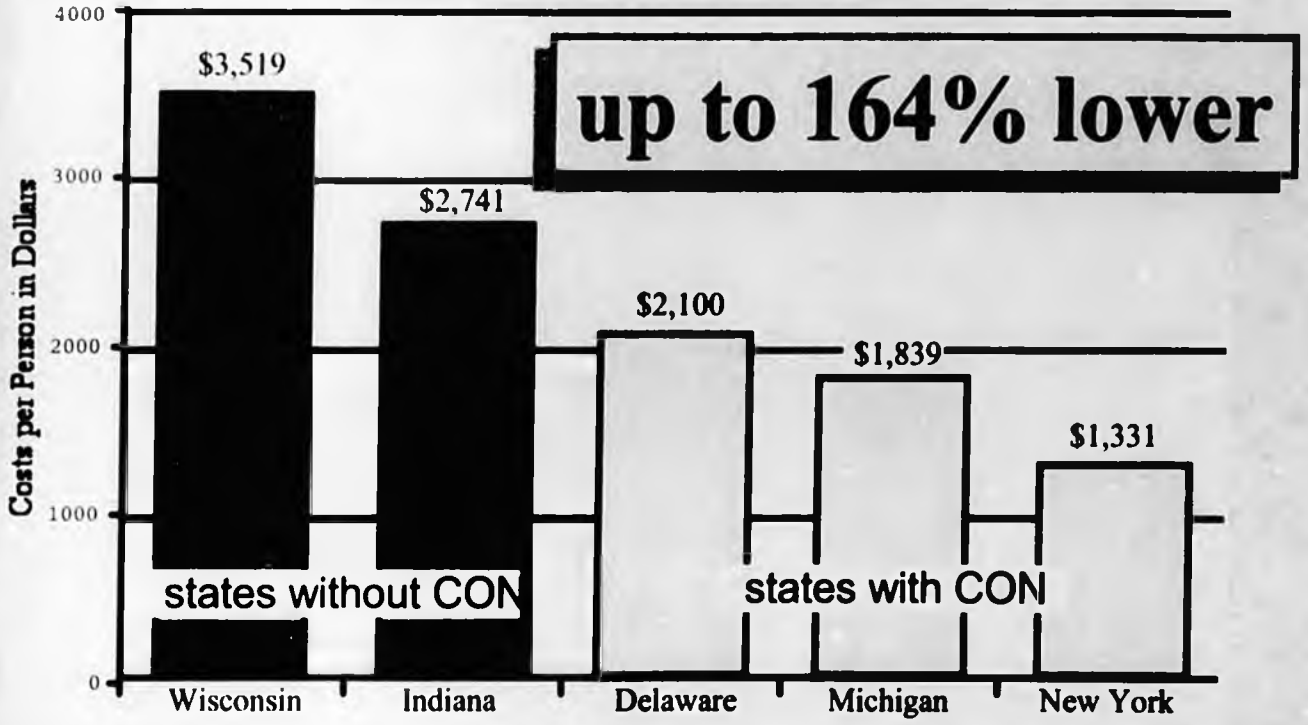


CON: Unique Planning and Regulatory Tool

- **Planning-based**, analytically-oriented, fact-driven
- **Open process**, with provision for direct public involvement
- **Structured to compensate** for market deficiencies & limitations and foster market efficiency
- **Designed to highlight and accentuate quality** unlike licensure and certification with their leveling effects
- **Promotes economic and quality competition** within the context of health care market realities
- **Practical and educational** rather than ideological
- **Doorway to excellence** rather than barrier to market entry

Big-Three Automakers Health Care Costs
non-CON vs. CON states

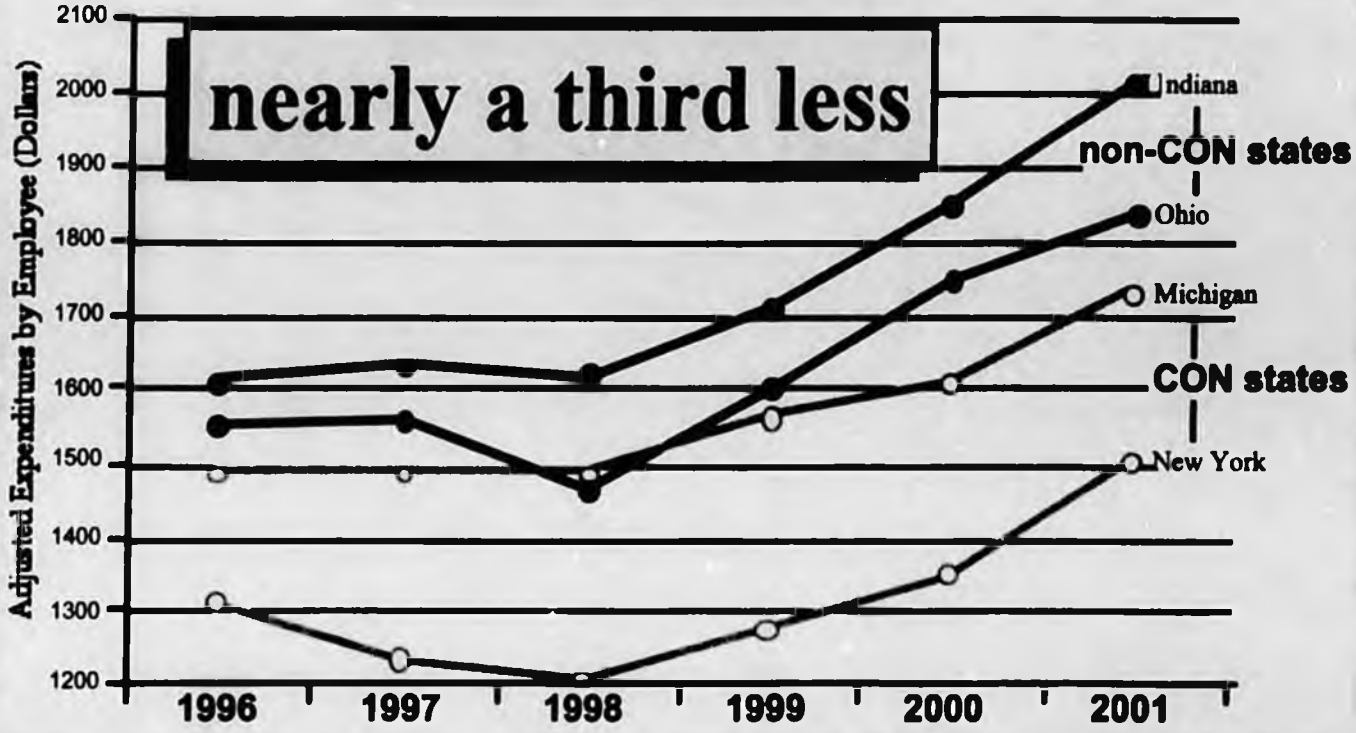
Adjusted Health Care Cost Per Person
By Location and State CON Status
DaimlerChrysler Corporation, 2000



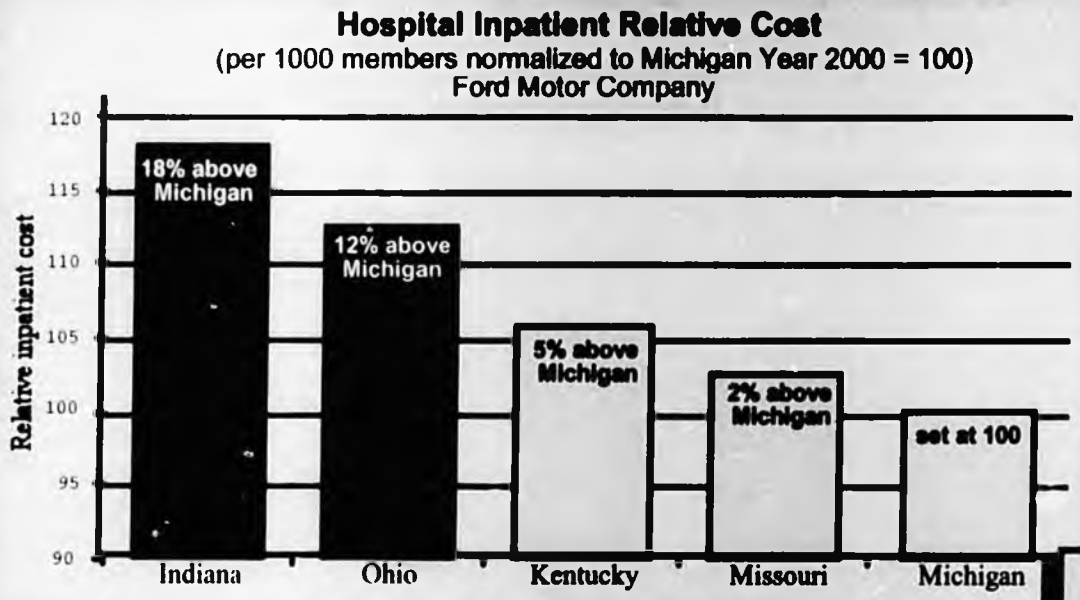
CON states have lower health care costs than non-CON states!

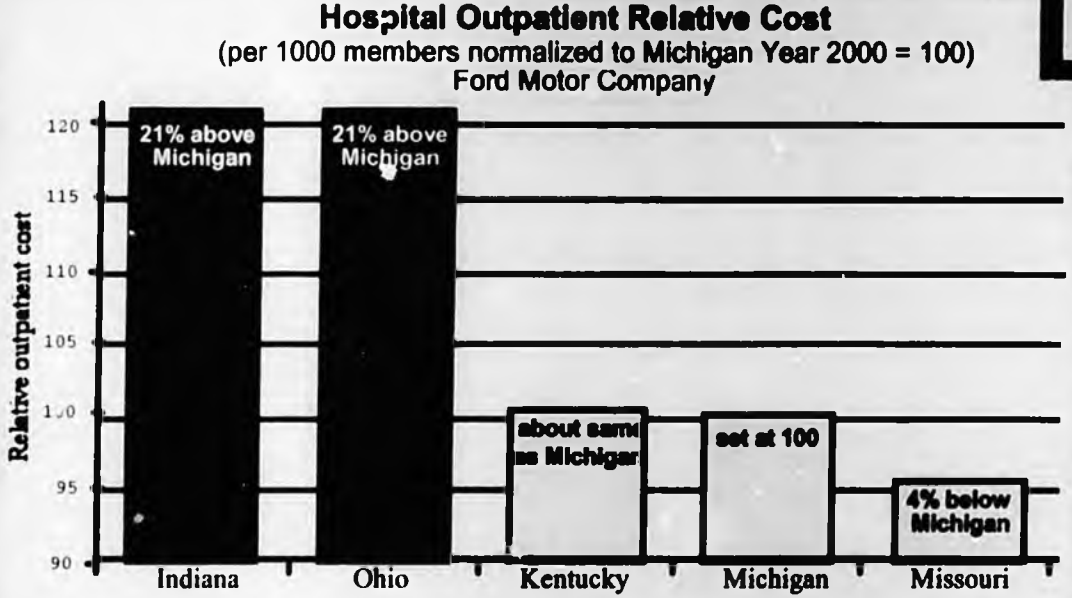
Big-Three Automakers Health Care Costs non-CON vs. CON states

Adjusted Health Care Expenditures Per Employee
By State and CON Regulation Status
General Motors Corporation, 1996-2001



CON states have lower health care costs than non-CON states!





Big-Three Automakers Health Care Costs non-CON vs. CON states

about 20% less

CON states have lower health care costs than non-CON states!

Consequences of Unrestricted Health Care Competition if SB 245 is approved



- Splinters the provider delivery network

- Threatens "safety net facilities"

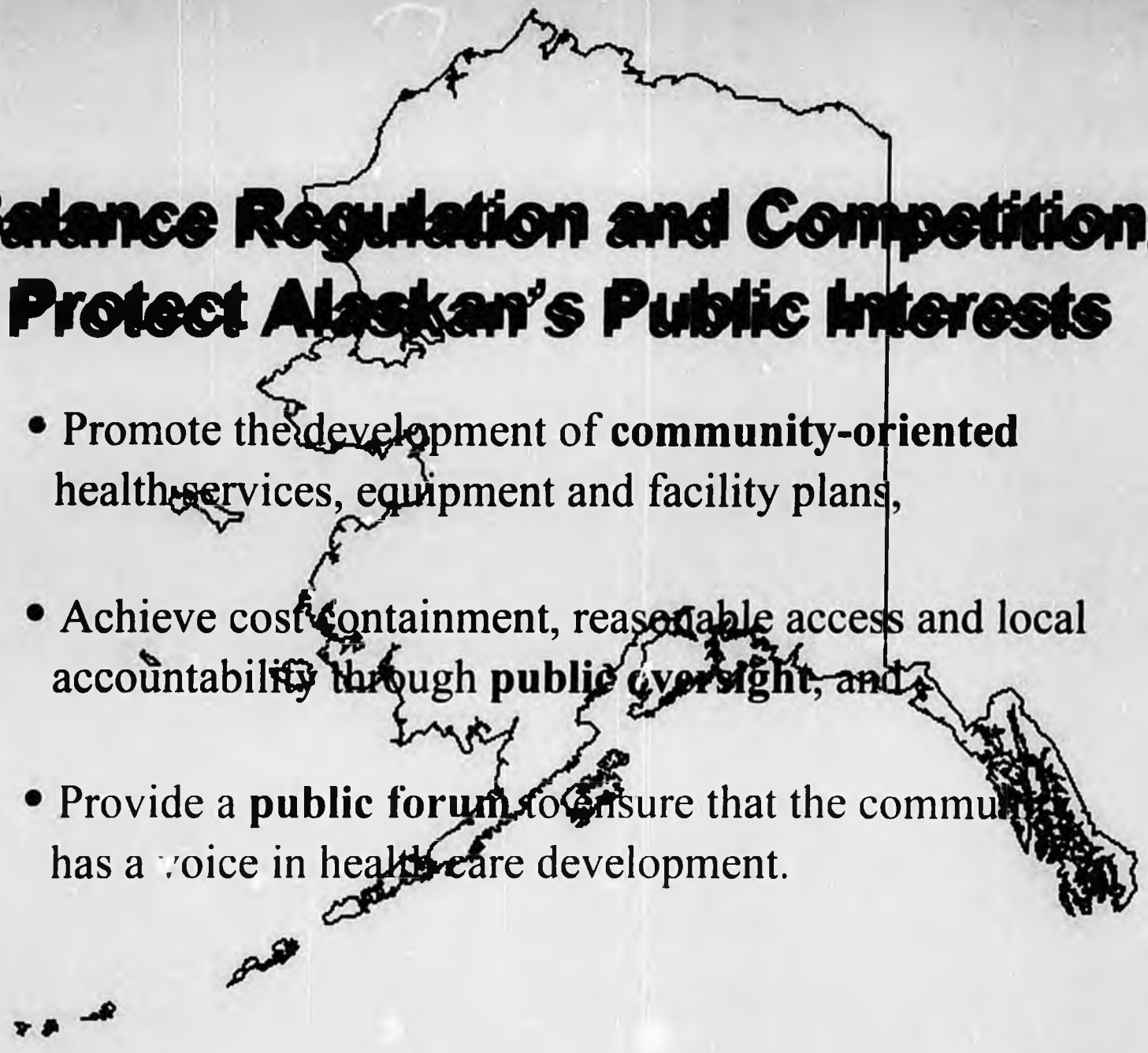
- Creates high-profit niche markets

- Supply drives demand!



Alaska Needs Health Care Public Oversight

- **Prices** for health care services are going up almost **8%** annually, compared to less than 2.6% inflation for most other services.
- Health care **spending** divides out to **$12,106** per family, which is 16% of the gross domestic product . . . this spending is projected to reach 20% by 2015 if current levels continue.
- Employer insurance **premiums** increased by **6.1%**, which threatens the ability of business to effectively compete in the domestic and world markets.
- High cost of health care is dipping into **retirement reserves** with average cost of nursing home care over $60,000 per year.



Balance Regulation and Competition: Protect Alaskan's Public Interests

- Promote the development of **community-oriented** health services, equipment and facility plans,
- Achieve cost containment, reasonable access and local accountability through **public oversight**, and
- Provide a **public forum** to ensure that the community has a voice in health care development.

Certificate of Need: Protecting Public Interests



Thank you, any questions?

Missouri CON . . . promoting responsive planning,
evaluating health systems and reducing unnecessary health costs



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Certificate of Need: Protecting Public Interests



Position on Senate Bill 245 - February 8, 2008
Prepared by: Rod Betit, President/CEO

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 SB 245 followed by a sectional analysis.

ASHNHA's POSITION ON SECTIONS CONTAINED IN SB 245(Version A):

▪ Section 1 - Statewide Health Plan:	SUPPORT AS IS
▪ Section 2 - Establish Alaska Health Care Commission	SUPPORT IF AMENDED
▪ Section 2- Establish Health Care Information Office & Establish Mandatory Reporting Requirement	SUPPORT IF AMENDED
▪ Section 3- Repeal CON authority	OPPOSE
▪ Section 4 - More CON Repeal Provisions	OPPOSE
▪ 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 - More CON Repeal Provisions	OPPOSE
▪ Section 9- More CON Repeal Provisions	OPPOSE
▪ Section 10 - CON Repeal Effective Dates	OPPOSE
▪ Section 11 - Statewide Health Plan Effective Date	SUPPORT AS IS
▪ Section 11 - Health Care Commission Effective Date	SUPPORT AS IS
▪ Section 11 - Health Care Information Office Effective Date	SUPPORT AS IS
▪ Section 11 - 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.

Section 2 - 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, SB 245 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 SB 245 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 2 - Establish Health Care Information Office & Mandatory Reporting Requirement:
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 4) 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 SB 245 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

ASHNHA Alaska State Hospital and Nursing Home Association

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.

Sections 3, 4, 6 7, 8, 9, and 10 - Repeal Certificate of Need:

ASHNHA's membership opposes these sections of SB 245. 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 SB 245 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 SB 245 and the Department asked to continue working with the Rulemaking Committee to refine CON regulations and processes to resolve any continuing concerns.

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

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

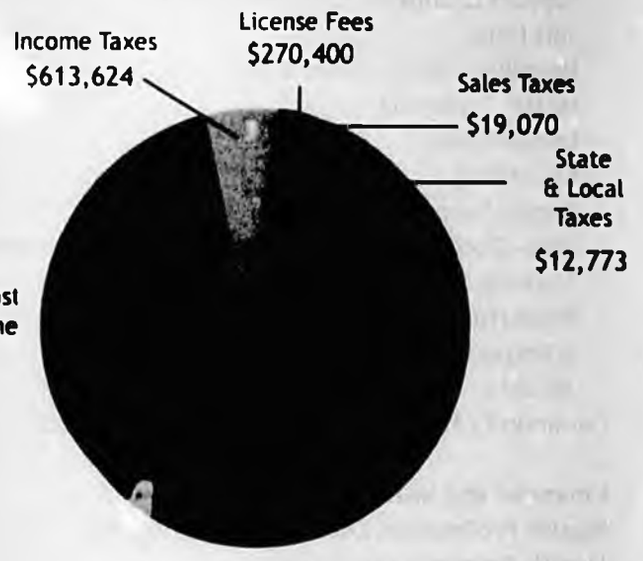
This report uses numbers to present the Community Benefits provided by Alaska hospitals. But Community Benefits are really about people. Community Benefits include care provided free of charge to Alaskans who are unable to pay. Programs and services can include prenatal care for expectant mothers and 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
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The Federal Trade Commission
&
Certificate of Need Regulation

An AHPA Critique

January 2005



American Health Planning Association

. . . putting it all together

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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.

II. Context & History

Improving Health Care is but the most recent, and perhaps the most visible, example of the decades-long FTC effort to shape the climate of opinion on health care.[4] In a February 9, 1987, letter to the Health Systems Agency of New York City, advising the agency to not try to reduc excess hospital bed capacity in the city, Jeffrey Zuckerman, Director of the FTC's Bureau of Competition, noted that the FTC had "been engaged in extensive efforts to preserve and promote competition in health care markets" for more than a decade.[5] A year earlier, Terry Calvani, FTC Acting Chairman, had made it clear that CON was a part of that effort:

> "A major initiative for the coming year . . . will be a program to halt actions by health-care providers which are designed to raise the costs and deter the entry of competitors. For example, state law frequently requires a hospital to obtain a "certificate of need" (CON) before it can build a new facility. The Commission has discovered that existing hospitals have sometimes opposed these CON applications, not in good faith, but merely to delay the entry of a new competitor and to burden it with heavy costs. The Commission will watch for such activities and will challenge them as trade restraints where appropriate."[6]

In other words, certificate of need (CON) regulation has long been anathema to the FTC. The Commission has actively opposed CON programs for at least the last two decades.

It is unclear how the FTC ascertained the motivation and intent of hospitals participating in CON review processes, but its attack on CON has not been limited to, or even meaningfully related to, preventing existing service providers from engaging in restraint of trade. Beginning in the mid-1980s, Commission staff regularly urged State policymakers and health care officials to eliminate or, alternatively, limit CON regulation. The period between 1986 and 1989 was particularly intense. Beyond its sustained generic opposition, during this period alone the FTC formally

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[4] Apparently, the Commission had no great concern about the structure and nature of the health care system before the advent the Medicare program and the economic and system changes dating from that period. There is little, if any, evidence of FTC concern about the structure and operational aspects of the health care system as long as its was dominated by market forces, i.e., before Medicare and other government-sponsored health and health-related programs.

[5] 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, p. 2.

[6] See FTC press release, February 21, 1986 at www.ftc.gov. See also FTC annual reports for 1986 and 1987. U.S. Federal Trade Commission, Washington, D.C.

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.

limits access to care. Whatever the focus of the argument presented in individual states, the underlying FTC argument in all cases was, and remains, that in health care—as in other sectors of the economy—an unregulated market is superior to planning and regulation in assuring quality, access and cost-effectiveness. In addition to consistently opposing CON regulation for at least the last 20 years, the FTC has also opposed related state planning and regulatory initiatives.[17]

Fourteen states have dropped their CON programs since the mid-1980s. It is not clear how many of these states, if any, responded to FTC arguments or recommendations. Commission staff was active in a number of them, responding to the inquiries of CON opponents, advising state lawmakers to oppose or otherwise limit CON regulation, and preaching the redeeming value of market forces in health care. FTC officials have devoted substantial effort to opposing CON regulation and appear to believe their campaign was necessary, if not uniformly successful. After a brief hiatus, they now appear ready to resume the crusade.

Ostensibly, *Improving Health Care* was issued as an "educational resource" to States and other interested parties. It is unclear how State policymakers will respond to the current FTC advice. Those engaged in the day-to-day struggle to make health care available and affordable, or at least nominally accessible, to all in need necessarily have proven resistant to the siren song of free markets and unfettered competition as ***the*** solution to cost, quality and access problems. Nevertheless, the 2004 report will certainly encourage opponents of CON, whatever their motivation.[18] There is likely to be much discussion in State legislatures during upcoming legislative sessions. CON regulation is likely to remain in the FTC crosshairs as long as a significant number of States have such programs.

III. Nature of the FTC Critique

Stated simply, the FTC argument against CON regulation holds that health care is as much subject to orthodox economic principles and doctrine as any other sector of the economy. Consequently, the best (i.e., the surest, most effective, most efficient) way to assure quality, efficiency, access, innovation, and lower prices is to rely on market forces and competition. The Commission recognizes that many do not view health care as a commodity that is, or should be, responsive to market forces. The authors lament that much of the public, nationally and internationally, view health care as "a special good" that is "not subject to normal market forces, with significant obligational norms to provide necessary care without regard to ability to pay."

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[17] The FTC opposed the enactment of "certificate of public advantage" legislation in a number of states in the 1990s. These legislative initiatives attempted to provide guidance and "safe harbors" for certain cooperative arrangements that appeared warranted, especially following the sharp nationwide reduction in inpatient hospital use during the previous decade, to promote efficiency and the financial viability of some services. On March 10, 1993, FTC staff advised North Dakota officials that such legislation "could raise costs and reduce quality". See FTC press release, March 10, 1993 at www.ftc.gov. Similar advice was presented to Vermont officials on October 20, 1994. See FTC press release, October 20, 1994 at www.ftc.gov.

[18] See, for example, the Virginia Department of Planning and Budget's *Economic Impact Analysis* of proposed revisions to Virginia's Certificate of Public Need State Medical Facilities Plan. The "analysis" is a gratuitous attack on certificate of need regulation, clearly modeled after the FTC argument and assumptions. Copies of the Virginia report are available from the Health Systems Agency of Northern Virginia, Falls Church, VA.

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.

recent empirical evidence of the value of regional planning and CON regulation in helping control costs and maintaining quality are dismissed by citing the anecdotal comments of CON opponents.[21]

To the extent the FTC argument against CON is grounded in analysis, it is based largely on three FTC staff reports produced in the mid-1980s. These are unusually weak studies. All three are macro econometric studies that involve multivariate regression analysis of aggregated data obtained from standard sources, e.g., state licensure programs, American Hospital Association surveys, and Medicare data. All are burdened by the inherent weaknesses of such examinations of the health care system. Concerns include whether the factors being examined are actually being measured, whether the data used are accurate, reliable, or relevant, and whether the methods used are actually applicable to the question raised. For example, though undertaken in the mid-1980s, the health service and cost data examined in the three FTC staff reports comes from 1977-78 (Noether, Hospital Competition). 1981 (Anderson, Home Health Care Costs), and 1983-84 (Sherman, Hospital Costs).

Underlying assumptions that planning and CON regulation of certain capital costs had (or could have) readily discernible effects in such a short period (PL 93-641 was enacted in 1974 and implemented in 1976) are problematic, attempts to account analytically for these deficiencies notwithstanding. The accuracy and reliability of the data used in these studies are equally questionable. If ever of any value, all three have been eclipsed by changes over the last two decades and have lost any relevance they may have had. Repeated citation by the FTC does not improve or add to the credibility of these studies, or of similar reports that have been cited repeatedly but conflict with experience.

Virtually all of the arguments against CON made by the FTC to State policymakers have been conjecture, based on theory and doctrine rather than acknowledged fact or demonstrated cause and effect. There are few reliable studies of the effects, if any, on the costs and charges for services subject to CON regulation. The results of studies that have been performed have been mixed. In the 1980s, when the FTC staff made representations about the negative effects of CON regulation on access, quality, innovation, and system efficiency, there were few, if any, studies or data that supported these arguments. They were assertions derived from an abiding faith in the effectiveness and unalloyed good of market forces.

Even today there are few studies that try to assess objectively the effects of CON regulation on regulated services. Whatever the purported results, all are regression and correlation studies that do not demonstrate or explain cause and effect. Recent studies that try to discern quality effects of CON regulation generally favor CON regulation.[22] Notwithstanding the repeated claims of FTC staff, there are still no reliable studies that show negative access, innovation, or system efficiency

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[21] Recent favorable reports of lower automaker health care costs in states with CON programs, and reports of lower open-heart surgery mortality rates in states with CON programs, are dismissed in this fashion.

[22] See, for example, General Motors Corporation. Statement of General Motors Corporation on the Certificate of Need (CON) Program in Michigan, February 12, 2002; Ford Motor Company. Relative Cost Data vs Certificate of Need (CON) for States in Which Ford has a Major Presence, February, 2002; DaimlerChrysler Corporation. Certificate of Need: Endorsement by DaimlerChrysler Corporation, February 2002. Vaughan-Sarrazin, MS, Hannan, EL, Gormley, CJ, Rosenthal, GE. "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation," JAMA, Vol. 288 No. 15, October 16, 2002, 1859-1866.

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

practices, particularly those of the Medicare program ("government administered pricing"), interfere with market forces and competition.[23]

The report cites approvingly the commentary of Newt Gingrich that "the third party payment model is inherently conflict ridden"[24] and that these insurance schemes "distort incentives and have unintended consequences". According to the report, these distortions explain the rise of ambulatory surgery centers and single-specialty hospitals, particularly cardiovascular services specialty hospitals. The import of the argument is that both Medicare and other third party payers are problematic because they shield individuals from the economic effects and implications of their health care choices and use. From the FTC perspective, if third party payment is to be permitted, high deductible and high co-payment coverage structures are desirable.

- *Government Purchasing of Services*. The report is highly skeptical of government purchasing of health care services on behalf of citizens, because it shields the recipient of such care from the disciplining effects of market forces. Hence, although neutrality is claimed on possible financing schemes, the authors warn against single-payer financing arrangements on the grounds that "government purchasing that reflects monopsony power would likely reduce output and innovation."[25] The report makes clear that this and related concerns apply to both the existing Medicare and Medicaid programs and to any expansion of them such as any effort (e.g., government purchasing or regulation) to control the costs of, or improve access to, prescription drugs.

- *Physician Self-Referral*. Although the FTC and DOJ are charged with preventing monopoly and rooting out restraint of trade practices, and oppose collective bargaining among independent physicians on these grounds, they show little concern about self-referral among physicians. They note approvingly that single-specialty hospitals (SSHs) established recently in states without CON programs "differ from their predecessors in that many of the physicians who refer patients have an ownership interest in the facility." Rather than question this arrangement, or examine carefully the significance of physician-driven decisions in health care and the underlying incentives and practices, the authors "encourage further research into the competitive significance of SSHs." The FTC is especially interested in determining "whether payors can discipline general acute care hospitals by shifting a larger percentage of patients to SSHs."[26]

- *Excess Capacity*. Stated simply, the "Roemer effect" is not recognized by the FTC. As indicated in its recommendation to the New York City Health Systems Agency, a market driven system does not have, or will not long have, excess capacity. According to market

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[23] "Any administered pricing system inevitably has difficulty in replicating the price that would prevail in a competitive market. Not surprisingly, one unintended consequence of the CMS administered pricing systems has been to make some hospital services extraordinarily lucrative and others unprofitable. As a result, some services are more available (and others less available) than they would be in a competitive market." ***Improving Health Care: A Dose of Competition, Executive Summary, p. 9.***

[24] "A large majority of consumers purchase health care through multiple agents. This multiplicity of agents is a major source of problems in the market for health care services. Agents often do not have adequate information about the preferences of those they represent or sufficient incentive to serve those interests." ***Improving Health Care: A Dose of Competition, Executive Summary,*** p. 11.

[25] ***Improving Health Care: A Dose of Competition, Executive Summary,*** p. 20.

[26] ***Improving Health Care: A Dose of Competition***, Chapter 3, p. 18.

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.

- *Prohibition of Physician Collective Bargaining*. Though a relatively small issue, the argument against collective bargaining among independent physicians is doctrinal in nature. The presumed negative effects of collective bargaining on quality and costs are theoretical. The FTC position appears to be more a statement of the Commission's social views, not one based on analysis or evidence.

- *Regulation of Pharmacy Benefits Manager Transparency*. The problems with prescription drug prices, and with obtaining reliable information about their efficacy and cost, are manifest. The FTC recommendation that there be no government regulation of pharmacy managers appears to be an attempt at preemption. The argument and recommendation are illustrative of the doctrinal nature of the FTC positions. The report acknowledges that accurate and reliable information is necessary, but rejects government action to ensure that such information is available to payers and consumers. It falls back on the doctrinal argument that a free market should be relied on to produce the information that is needed to discipline the system.

- *Service mandates*. As with cross-subsidization, the FTC argument against service mandates is based largely on orthodox economic theory, and hence doctrinal in nature. There is no meaningful analysis of the rationale for, the value of, or the costs of mandates compared with alternatives. The merits and costs of service coverage mandates should be reviewed periodically, but eliminating them in the name of economic orthodoxy is not warranted.

VIII. Arguments Against FTC Assertions and Assumptions

- *The health care market is inherently imperfect*. The FTC recognizes that the usual benefits of competition are not achievable in the health care system under current conditions. The report acknowledges a number of glaring market imperfections that need to be cured if market forces and competition are to have their presumed beneficial effects. The problems cited include the mediating influence of service selection and purchasing intermediaries such as insurance, Medicare, physicians and other health care professionals, the lack of price and quality information, legislatively imposed service mandates, cross-subsidization within the system, and service to all in urgent and emergent circumstances regardless of ability to pay.

  The report argues that these imperfections should be cured as quickly as possible. Whatever the merit of this view and argument, cures are not likely soon. Even if acted upon aggressively, the changes required would take years to accomplish in most cases. Community-based planning and CON regulation are linked to, and help compensate for, a number of these imperfections. It is important to maintain and strengthen planning and targeted CON regulation until the related market imperfections are corrected.

- *Health care is not, and should not be treated as, a commodity*. Although the FTC does not state directly that health care should be treated as an economic commodity, its arguments and assumptions make practical sense only if that were the case. Even in theory, much less in practice, market forces can have the system-shaping effects the FTC calls for, and argues will result from unfettered competition, only if health care is treated as any other economic good. The report laments that many, if not most, people see health care as "a special good" that is not, and should not be, subject to orthodox market forces. The

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

level of quality that they prefer."[28] Presumably, the poor might "prefer" a "level of quality" consonant with what they could afford. As with any other commodity, an unfettered health care system will offer many different quality levels or categories, in both clinical and economic terms.

IX. Arguments in Favor of Planning and CON Regulation

- *CON is a useful market balancing tool*. In a necessarily imperfect, and an increasingly inequitable, health care system, community-based planning and CON regulation are flexible tools that, when used intelligently and objectively, help protect the critical health care infrastructure that is required to meet both expected and unanticipated public need. Market forces are invaluable in balancing the cost, supply, access, and quality of most goods and services. Market fluctuations and vagaries are acceptable for most commodities, but are problematic for essential social goods and services, especially health care.

- *Under current and expected health system market conditions, community-based planning and CON regulation are useful in promoting competition*. CON regulation, and related planning, can be and has been used to provide consumers and other purchasers with price and quality information. They also are used to stimulate direct competition and market entry where evidence indicates this would improve system operations and efficiency.

- *Recent empirical evidence shows substantial economic and service quality benefit from CON regulation and related planning*. Empirical studies by all three major U.S. automakers show substantially lower health care costs in states with CON programs.[29] Similarly, the most recent and largest study of CON regulation on treatment outcomes found that open heart surgery mortality rates are more than 20% lower in states with CON regulation than in states without regional planning and regulation.[30]

- *CON regulation is one of the few practical planning tools available to policymakers.* Whatever its limitations, CON regulation, with related community-based planning, is one of the few tools that policymakers, health system officials, and ordinary citizens have available for use in trying to compensate for known weaknesses and deficiencies in the existing health care system. CON decision-making processes provide a unique forum where all interested parties, and ordinary citizens, can express their views and state their needs. This oversiight is distinct in that it often is the only light available to illuminate important quality, cost, and access concerns that are important to consumers.

- *CON regulation is the only practical tool available to implement basic planning policies and practices*. The relationship between average annual service volume and treatment

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[28] ***Improving Health Care: A Dose of Competition,*** *Executive Summary*, p. 5.

[29] General Motors Corporation. *Statement of General Motors Corporation on the Certificate of Need (CON) Program in Michigan*, February 12, 2002; Ford Motor Company. *Relative Cost Data vs Certificate of Need (CON) for States in Which Ford has a Major Presence*, February, 2002; DaimlerChrysler Corporation. *Certificate of Need: Endorsement by DaimlerChrysler Corporation*, February 2002.

[30] Vaughan-Sarrazin, MS, Hannan, EL, Gormley, CJ, Rosenthal, GE. "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation," *JAMA*, Vol. 288 No. 15, October 16, 2002, *1859-1866.*

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.

- **CON is an important health policy tool that balances community need with growth.**

  - There are many examples of health care projects initiated in communities around the country where "profit" motives take priority above overall "community good". The CON review process focuses on these issues and assures the project is in the best interest of patients as well as the community.

  - Without a strong CON process, over-building of health care services will occur in some areas, while critically needed medical services will not be developed in other areas. Developers will go into geographic areas where they see an opportunity, not into areas where they see marginal return on investment.

  - 36 states plus the District of Columbia continue to require CON approval for one or more categories of health services. Further, some states have gone beyond CON and put moratoriums in place to prohibit growth in certain medical services.

- **Current CON laws are not preventing needed growth in Alaska's health care infrastructure.**

  - Since reopening of the CON process in 2005, the Department of Health & Social Services has approved a number of new health care projects and has allowed others to proceed without CON review.

  - Alaska's hospitals and nursing homes are required to apply for CON approval before embarking on any new expansion project. Other parties interested in providing health care services should be exposed to the same rigorous review with the exception of 'physician offices' which are exempted from CON under current law.

- **Over building of medical infrastructure will worsen Alaska's workforce shortage.**

  - Alaska is already facing a critical shortage of physicians and nurses. This situation is not expected to improve in the short term. Many of the projects subject to CON review would require the most specialized professionals in radiology and surgery.

  - If we do not control the growth in Alaska's medical infrastructure we will see staffing shortages in our hospitals and nursing homes beyond anything we have experienced to date.

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The Effects of Certificate-of-Need Repeal on Medicaid Long-Term Care Expenditures.

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Abstr Acad Health Serv Res Health Policy Meet. 2001; 18: 99.

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RESEARCH OBJECTIVE: Certificate-of-need (CON) programs have been widely used to control the growth in nursing homes and thereby limit state Medicaid expenditures. However, CON policies have been found to be associated with lower nursing home quality and restricted access to services for Medicaid recipients. In recent years, a number of states have repealed their CON laws as they apply to nursing homes. This study examined the effects of these CON repeals on Medicaid long-term care expenditures.STUDY DESIGN: We estimated a set of regression equations using a pooled time series of state level Medicaid long-term care expenditures from the period 1981 through 1996. The analysis is complicated by the fact that CON repeals and other Medicaid programmatic variables are simultaneously determined with Medicaid expenditure levels. Thus, we estimated both a simple one equation model and a two-stage least squares model, which accounts for the simultaneity issue.PRINCIPAL FINDINGS: Using either a simple one equation model or the more complex multi-equation approach, preliminary analyses provided no evidence that Medicaid long term care expenditures increased when CON laws were repealed. In fact, our analyses indicated that CON repeal was associated with lower Medicaid expenditures. The data also suggested that it has been the level of Medicaid nursing home payment that has been the policy variable responsible for lower Medicaid expenditures.CONCLUSIONS: This paper provided evidence that the repeal of CON legislation has not led to significantly higher Medicaid long-term care expenditures. Implication for Policy, Delivery, or Practice: There is a large literature that concludes hospital CON laws are ineffective at constraining public expenditures. Nevertheless, Medicaid policymakers have always assumed that CON reduced nursing home expenditures. This study suggests that state Medicaid programs may wish to re-visit the use of CON programs as they pertain to nursing homes.

Publication Types:
- Meeting Abstracts

Keywords:
- Health Expenditures

THE EFFECTS OF COMPETITION ON VARIATION IN THE QUALITY AND COST OF MEDICAL CARE

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We estimate the effects of hospital competition on the level of and the variation in quality of care and hospital expenditures for elderly Medicare beneficiaries with heart attack. We compare competition's effects on more-severely ill patients, whom we assume value quality more highly, to the effects on less-severely ill, low-valuation patients. We find that low-valuation patients in competitive markets receive less intensive treatment than in uncompetitive markets, but have statistically similar health outcomes. In contrast, high-valuation patients in competitive markets receive more intensive treatment than in uncompetitive markets, and have significantly better health outcomes. Because this competition-induced increase in variation in expenditures is, on net, expenditure-decreasing and outcome-beneficial, we conclude that it is welfare-enhancing. These findings are inconsistent with conventional models of vertical differentiation, although they can be accommodated by more recent models.

1. INTRODUCTION

Recent studies have emphasized the importance of vertical differentiation in markets for hospital services. Yet, most analyses of how hospitals compete do not investigate competition's effects on hospitals' strategic choice of quality of care. In this paper, we estimate empirically how

We thank Jeanine Balbach, Harrison Hong, David Hyman, Paul Pautler, Jane Ruseski, Bill Sage, Dave Scheffman, Mike Vita, Bill Vogt, and Joel Waldfogel for helpful discussions, and the Federal Trade Commission and the National Institute on Aging through the NBER for generous support. David Becker provided exceptional research assistance. The views expressed in this paper do not necessarily reflect those of any of the author's institutions or the Federal Trade Commission.

© 2005 Blackwell Publishing, 350 Main Street, Malden, MA 02148, USA, and 9600 Garsington Road, Oxford OX4 2DQ, UK.
Journal of Economics & Management Strategy, Volume 14, Number 3, Fall 2005, 575–589

conventional measures of hospital market competitiveness affect the distribution across patients of health outcomes and medical expenditures. This contributes to the existing literature in at least three ways.

First, different theoretical models offer opposing predictions of how competition affects vertical differentiation. Thus, empirical evidence can be used to test such models against one another. Second, estimates of the effect of competition on vertical differentiation are important for policy making. For example, understanding whether competition benefits all patients equally, or benefits some patients at the expense of others, improves the targeting and coordination of antitrust and other health care quality regulatory policies. Third, many researchers have argued that the substantial variation in the cost of medical care across geographic areas is socially wasteful (see Fisher et al., 2003 for a comprehensive cataloging of this work). Estimates of the effect of competition on area variation in quality and cost can therefore indicate whether at least a portion of this variation is socially constructive or harmful.

In particular, we investigate how competition in hospital markets, as measured by a Hirschman-Herfindahl index (HHI), affects the health care utilization and outcomes of essentially all non-rural elderly individuals enrolled in traditional fee-for-service Medicare who suffered a new heart attack (AMI) between 1985 and 1996. We estimate the extent to which the HHI has different effects on patients with prior year hospital utilization and those without it, holding constant five-digit-zip-code fixed effects and other characteristics of individuals and hospital markets. Because the health outcomes of prior-year-hospitalized AMI patients are substantially worse (and their utilization substantially higher), we describe them as "high-risk" and their prior-year-nonhospitalized counterparts as "low-risk". Consistent with previous research (e.g., Capps et al., 2003), we assume that high-risk patients have a higher willingness to pay for quality than low-risk patients. By examining how the HHI affects each of these two group's subsequent outcomes and expenditures, we explore both how competition affects variability in quality and how this competition-induced change in vertical differentiation affects social welfare.

The paper proceeds as follows. Section 1 briefly summarizes the previous research on this subject. Section 2 outlines our data and models. Section 3 presents our results. Section 4 concludes.

2. Previous Research

Eliminating an independent competing hospital from a market changes neighboring hospitals' strategic incentives, thereby changing the types

of treatment, prices, and qualities that they offer. According to this reasoning, the welfare effect of a change in competitiveness, such as a proposed merger, is determined by comparing the quality of and expenditures on treatment in competitive and uncompetitive markets, holding all other observed factors constant (e.g., Kessler and McClellan, 2000).

Yet, as Tay (2003) shows, such an analysis is not a complete description of how hospitals compete. Quality may not be wholly endogenous. For example, if some hospitals are permanently high quality and others permanently low quality, then the effects of mergers may not be accurately predicted by a model that fails to account for vertical differentiation. In addition, even if quality is endogenous, simply knowing the average or total effect of a change in competition leaves many important issues unresolved. Changes in competition may benefit patients in aggregate but still harm some subgroups.

Theoretical models of vertical differentiation illustrate how this can happen. Conventional models (e.g., Gabszewicz and Thisse, 1980; Shaked and Sutton, 1982) emphasize how oligopoly increases quality variation at the expense of social welfare: firms try to relax price competition through differentiation (see Tirole, 1989, section 7.5.1. for an excellent exposition of these models). In markets for hospital services, these models imply that oligopoly hospitals lower the quality of care for low-risk (i.e., low-valuation) patients in order to be able to charge their high-risk (i.e., high-valuation) counterparts more. In the terms of our empirical models, competitive markets should have less variation in quality and expenditures, lower rates of mortality and cardiac complications for low-risk patients, and lower expenditures for high-risk patients.

In more recent work, however, Acharyya (1998) shows that without restrictions on cost functions, uncompetitive markets may or may not have more quality variation. Indeed, in an oligopoly model incorporating both horizontal and vertical differentiation, Anderson and De Palma (2001) show that under certain assumptions the unique equilibrium has all firms choosing a single (sub-optimal) quality. In the terms of our empirical models, more recent work allows uncompetitive markets to have higher rates of adverse outcomes and lower expenditures for high-risk patients, or low-risk patients, or both.

In this paper, we empirically test the hypotheses of these models. We separate patients into two groups: those with a low versus a high valuation of quality based on a measure of their health status at the time of onset of illness. By estimating the effect of concentration on the mortality, cardiac complications, and medical expenditures of low- and high-valuation patients, and for patients overall, we investigate the

extent to which conventional models of vertical differentiation explain behavior in hospital markets. In addition, these estimates allow us to identify the welfare consequences of competition-induced variation in quality. If an increase in variation leads to lower expenditures and better outcomes, then we conclude that it would increase welfare. If it leads to higher expenditures and worse outcomes, then we conclude that it would decrease welfare. If it leads to lower expenditures and worse outcomes (or higher expenditures and better outcomes), then we calculate the implied cost per life saved to determine its welfare effects.

3. Data and Models

3.1 Data

We use data from three sources. First, we use comprehensive individual-level longitudinal Medicare claims data from the Centers for Medicare and Medicaid Services (CMS) on the medical utilization of virtually all nonrural elderly fee-for-service Medicare beneficiaries with a new occurrence of a heart attack (AMI) in 1985–1996. We determine whether the individual had acute care hospital utilization in the year prior to his or her AMI as a measure of the severity of his or her illness. We calculate several measures of utilization in the year after the individual's AMI, including the following: total acute and non-acute (mostly skilled nursing) Medicare expenditures (including deductibles and co-payments) and total acute and non-acute days in the hospital in the year following their admission for the study illness. Measures of utilization include all inpatient reimbursements (including co-payments and deductibles not paid by Medicare) from claims for all hospitalizations in the year following each patient's initial admission. Measures of the occurrence of cardiac complications were obtained by abstracting data on the principal diagnosis for all subsequent admissions (not counting transfers and readmissions within 30 days of the index admission) in the year following the patient's initial admission. Cardiac complications included re-hospitalizations within 1 year of the initial event with a primary diagnosis (principal cause of hospitalization) of either subsequent AMI or heart failure (HF). Treatment of AMI patients is intended to prevent subsequent AMIs if possible, and the occurrence of HF requiring hospitalization is evidence that the damage to the patient's heart from ischemic disease has serious functional consequences. Data on patient demographic characteristics were obtained from CMS's HISKEW enrollment files, with death dates based on death reports validated by the Social Security Administration. The CMS HISKEW enrollment files include demographic information on virtually all elderly Americans (including those enrolled in Medicare HMOs) because of the extremely high rate of take-up in the Medicare program.

Second, we use data on US hospital characteristics collected by the American Hospital Association (AHA). The response rate of hospitals to the AHA survey is greater than 90%, with response rates above 95% for large hospitals (>300 beds).

Third, we use a hospital system[1] database constructed from multiple sources (see Madison, 2001 for a detailed discussion). The AHA survey contains extensive year-by-year information on hospital system membership status. Our validity checking indicated that the universe of systems and system hospitals, and the timing of hospitals' system membership, as defined by AHA did not conform to discussion of hospital systems in the trade press such as Modern Healthcare. We, therefore, created our own system database based on a combination of the AHA and other sources.

3.2 Models

We model the effect of competition on the level and the dispersion between high-risk and low-risk patients of quality and medical expenditures. We identify the effect of competition with an HHI that is a function of distances from each patient to his hospital choices and other exogenous characteristics of patients and hospitals. To do this, we use a three-stage method.[2]

First, we specify and estimate patient-level hospital choice models as a function of exogenous determinants of the hospital admission decision. We do not constrain hospital geographic markets based on a priori assumptions. We allow each individual's potentially relevant hospital market for cardiac-care services to include all nonfederal, general medical/surgical hospitals within 35 miles of the patient's residence with at least five admissions for AMI, and any large, nonfederal, general medical/surgical teaching hospital within 100 miles of the patient's residence with at least five AMI admissions. We model the extent to which hospitals of various types at various distances from each patient's residence affect each patient's hospital choice, and we also allow each patient's demographic characteristics to affect his or her likelihood of choosing hospitals of one type over another. The results of these models of hospital demand provide predicted probabilities of admission for every patient to every hospital in his or her potentially relevant geographic market. We then estimate the predicted number of patients admitted to each hospital in the US, *based only on the geographic distribution and other observable, exogenous characteristics of patients and hospitals*.

1. We define hospitals as members of a system if they are owned or controlled, in whole or in part, by a common entity.

2. The following explanation follows the explanation in Kessler and McClellan (2000); that paper also contains a formal derivation of these methods.

Second, we calculate measures of competitiveness that are a function of these predicted patient flows (rather than actual patient flows or capacity), and assign them to patients based on their probabilistic hospital of admission (rather than their actual hospital of admission). Thus, the measure of competitiveness that we assign to each patient is uncorrelated with unobserved heterogeneity across individual patients, individual hospitals, and geographic hospital markets. We also calculate measures of the geographic density of the size distribution, teaching status, system-membership status, ownership status, and bed capacity per patient using predicted patient flows matched to each patient's area hospital characteristics.

Third, we use these unbiased indices of competitiveness, and interactions between these indices and a measure of patients' health at the time of onset of illness, to estimate the impact of competition on the level and dispersion of adverse health outcomes and utilization, holding other patient and area characteristics constant. In these models, observational units in our analysis consist of individuals $i = 1, \ldots, N_{zt}$ (in zipcode z and state s during year $t = 1, \ldots, T$) who are initially admitted to the hospital with a new occurrence of heart attack. Each patient has observable demographic characteristics X_{izt}: four age indicator variables (70–74 years, 75–79 years, 80–89 years, and 90–99 years; omitted group is 65–69 years), gender, and Black/non-Black race; plus a full set of interaction effects between age, gender, and race; and interactions between year and each of the age, gender, and race indicators. Each patient has health status A_{izt}, where $A_{izt} = 1$ if the patient was high risk (i.e., had an acute care hospital utilization in the year prior to his or her AMI). The patient then receives treatment of aggregate intensity R_{izt}, where R is one of five measures. The patient has a health outcome O_{izt}, possibly affected by the intensity of treatment received, where a higher value denotes a more adverse outcome (O is binary in all of our outcome models).

We match to each patient by zip code and year several measures of the hospital market environment that have been shown to affect treatment and quality of care: the competitiveness of zip code z's hospital market at time t (HHI_{zt} = whether z was in the top or middle quartiles of the distribution of HHIs of predicted patient flows), and whether z had above the median density of patients admitted to large hospitals, teaching hospitals, hospitals that were members of multi-hospital systems, for profit versus nonprofit hospitals, and public versus nonprofit hospitals at time t (J_{zt}). To measure market size and isolate the effects of competition-induced dispersion from the effects of market-size-induced dispersion, we calculate each zip code's bed capacity and population at time t (K_{zt} and P_{zt}). In the presence of fixed costs, larger markets support

a greater number of firms, which can lead to an observed positive correlation between variety and competitiveness even in the absence of any causal effect (see Berry and Waldfogel, 1999, for discussion of these models).

We estimate linear models of outcome and utilization effects as a function of five-digit zip-code and year-fixed effects (α_z and δ_t); demographic characteristics (X_{izt}); health status (A_{izt}); competitiveness (HHI_{zt}); size, teaching, system, and ownership status distribution of area hospitals (J_{zt}); and bed capacity and population at time t (K_{zt} and P_{zt}). We allow the effect of market environment to vary depending on the individual's health status A_{izt}:

$$\begin{aligned}\ln(R_{izt}) = {} & \alpha_z + \delta_t + X_{izt}\phi + A_{izt}\Phi \\ & + I(A_{izt} = 0) * (HHI_{zt}\beta + J_{zt}\gamma + K_{zt}\delta + P_{zt}\eta) \\ & + I(A_{izt} = 1) * (HHI_{zt}\beta^A + J_{zt}\gamma^A + K_{zt}\delta^A + P_{zt}\eta^A) + \epsilon_{izt}, \quad (1)\end{aligned}$$

O_{izt}

where R_{izt} is total hospital expenditures, acute care hospital expenditures, non-acute care hospital expenditures, acute care hospital days, or non-acute care hospital days; O_{izt} is readmission for AMI within 1 year, readmission for heart failure within 1 year, or mortality within 1 year; $I(\cdot)$ is the indicator function; and ϵ_{izt} is an independently distributed error term, with $E(\epsilon_{izt}|\ldots) = 0$.

4. Results

Table I presents trends in the distribution of Medicare expenditures and health outcomes for high-risk and low-risk patients. The fraction of patients whom we classify as high-risk ranges from 31.3% in 1985 (=49441/(108626 + 49441)) to 28.5% in 1996 (=44337/(111370 + 44337)). Our proxy for health is strongly and positively correlated with age and subsequent rates of adverse outcomes. High-risk patients are older, almost twice as likely to be readmitted with heart failure in the year after their AMI, and fully 14.7 percentage points more likely to die in the year after AMI (on a sample average mortality of 36.6%).

Although variation in utilization between high-risk and low-risk patients has risen over time in some dimensions, it has fallen in others. In particular, although the gap between the numbers of days spent in an acute care hospital in the year after AMI by high-risk versus low-risk patients rose from 21.3 to 27.1%, the gap between the total expenditures for a high-risk versus a low-risk patient fell from 12.5 to 8.3%. This shrinking of the high-risk versus low-risk expenditure gap is composed of a shrinking of the gap between the acute care expenditures of high-risk versus low-risk patients (in dollar terms, from

TABLE I.
DESCRIPTIVE STATISTICS OF PATIENTS

	1985			1996		
	Low-risk	High-risk	Difference	Low-risk	High-risk	Difference
AMI Readmission Rate in Year After AMI	5.4%	7.1%	1.7%	4.5%	6.9%	2.4%
HF Readmission Rate in Year After AMI	6.8%	10.9%	4.7%	6.8%	13.3%	6.5%
Mortality Rate in Year After AMI	36.2%	48.7%	12.5%	29.0%	43.7%	14.7%
Age	75.2	76.8	2.1%	76.6	78.1	2.0%
Black	5.3%	6.3%	1.0%	5.9%	8.2%	2.3%
Female	47.9%	53.4%	5.5%	49.1%	54.7%	5.6%
Total Hospital Expenditures	$13,733	$15,447	12.5%	$21,077	$22,827	8.3%
In Year After AMI (1993 $)	(12,612)	(15,086)		(20,785)	(22,626)	
Acute Expenditures	$13,855	$15,270	11.8%	$19,467	$20,378	4.7%
In Year After AMI (1993 $)	(12,238)	(14,905)		(18,706)	(19,967)	
Acute Days	16.8	20.4	21.3%	13.3	16.9	27.1%
In Year After AMI	(15.3)	(19.5)		(12.9)	(16.6)	
Non-acute Expenditures	$119	$179	50.4%	$1,604	$2,452	52.9%
In Year After AMI (1993 $)	(1,224)	(1,276)		(5,874)	(7,188)	
Non-acute Days	2.0	2.7	32.3%	4.7	6.8	44.7%
In Year After AMI	(10.0)	(12.8)		(13.4)	(16.9)	
N	108,626	49,441		111,370	44,337	

Notes: Standard deviations in parentheses. For 1985, number of patients = 158,067, number of zip codes = 7,048; for 1996, number of patients = 155,707, number of zip codes = 7,814.

$1,615 (=$15,270 – $13,655) to $908 (=$20,375 – $19,467)) and an expansion of the gap between the non-acute care expenditures (in dollar terms, from $80 (=$179 – $119) to $848 (=$2,452 – $1,604)) of the high-risk versus the low-risk.

Table II presents estimates of equation (1), the effects of competitiveness and other market characteristics on treatment intensity and health outcomes, allowing the effect of market environment to vary depending on the individual's health A_{ist}. The first row of Table II confirms that prior-year acute care hospital utilization is strongly and positively correlated with subsequent intensity of treatment and rates of adverse outcomes. Holding constant their demographic characteristics, area-fixed effects, and other market characteristics, high-risk AMI patients have approximately 8.3% higher inpatient expenditures, 9.8% more inpatient days, 1.4 percentage points higher rates of readmission for AMI, 4.8 percentage points higher rates of readmission for heart failure, and almost 11 percentage points higher 1-year mortality in the year after their AMI than their low-risk counterparts.

The top panel of Table II shows that competitive markets have lower expenditures for low-risk patients but not significantly worse quality of care. Among the approximately 70% of patients who are low-risk, total hospital expenditures in the year after AMI were approximately 1.3% higher in the least-competitive as compared to the most-competitive hospital markets; living in a moderately-competitive market (the middle two quartiles of HHIs) leads to almost as large of an effect on expenditures. The effect is present in both acute and non-acute care settings, although substantially larger in percentage terms in non-acute care. Effects of competition on outcomes are extremely small and statistically insignificant.

The bottom panel of Table II shows that competitive markets have higher expenditures on and higher quality of care for high-valuation patients. Total hospital expenditures in the year after AMI were approximately 1.2% lower in the least-competitive quartile of hospital markets, as compared to the most competitive markets. This effect is exclusively due to a decrease in acute care; providers in the least-competitive markets actually supply slightly more non-acute care. In addition, competition has large and statistically significant outcome consequences. Patients in the least-competitive hospital markets experience 0.82 percentage points higher 1-year mortality than do patients in the most-competitive markets; this effect is smaller but still significant for patients in moderately-competitive markets.

These effects are substantial. In competitive markets, the difference in expenditures between high-risk and low-risk patients is approximately 2.5% higher (=1.235 – (–1.274)) than in uncompetitive markets;

TABLE II.

EFFECTS OF HOSPITAL MARKET COMPETITIVENESS AND AREA DENSITY OF HOSPITAL CHARACTERISTICS ON MEDICARE UTILIZATION AND HEALTH OUTCOMES OF AMI PATIENTS, 1985–1996, ALLOWING EFFECTS TO VARY FOR PATIENTS WHO ARE HIGH-RISK AND LOW-RISK AT THE ONSET OF ILLNESS

	Dependent Variable							
	ln(Total Hospital Expenditures)	ln(Acute Expends)	ln(Acute Days in Hospital)	ln(Non-acute Expends)	ln(Non-acute Days in Hospital)	AMI Readmit Within 1 Year	HF Readmit Within 1 Year	Dead Within 1 Year
High-risk at Onset of Illness	8.384**	7.088**	9.845**	31.083**	11.525**	1.366**	4.829**	10.965**
	(0.713)	(0.714)	(0.784)	(1.770)	(0.668)	(0.180)	(0.221)	(0.365)
Effects of Competition and Area Hospital Characteristics for Low-risk Patients								
Very Concentrated Hospital Market	1.274**	1.055**	0.585	7.219**	2.353**	−0.014	0.071	0.221
(Top Quartile of HHIs)	(0.525)	(0.526)	(0.577)	(1.308)	(0.492)	(0.132)	(0.163)	(0.268)
Concentrated Hospital Market	0.955**	0.803**	−0.051	4.375**	1.258**	−0.101	0.000	−0.088
(Middle Two Quartiles of HHIs)	(0.382)	(0.382)	(0.420)	(0.947)	(0.357)	(0.096)	(0.118)	(0.197)
Above Median Density of	0.666**	0.692**	0.101	−0.779	−0.218	0.074	−0.011	0.089
Large Hospitals [Median = 0.220]	(0.319)	(0.319)	(0.351)	(0.792)	(0.299)	(0.080)	(0.099)	(0.165)
Above Median Density of	−1.330**	−1.398**	0.292	2.936**	1.494**	0.057	0.170	0.098
For-profit/Nonprofit [Median = 0.012]	(0.381)	(0.382)	(0.419)	(0.947)	(0.357)	(0.096)	(0.118)	(0.197)
Above Median Density of	0.883**	0.956**	−0.006	−1.632*	−0.216	0.028	0.005	0.213
Public/Nonprofit [Median = 0.029]	(0.354)	(0.354)	(0.389)	(0.879)	(0.332)	(0.089)	(0.109)	(0.183)
Above Median Density of	−0.091	−0.186	−0.640*	3.352**	0.846**	−0.055	0.038	−0.369**
Teaching Hospitals [Median = 0.141]	(0.302)	(0.303)	(0.332)	(0.750)	(0.283)	(0.076)	(0.094)	(0.156)
Above Median Density of	−1.335**	−1.225**	−0.748**	−1.377**	−0.334	−0.053	0.149*	−0.136
System Hospitals [Median = 0.525]	(0.262)	(0.262)	(0.288)	(0.649)	(0.245)	(0.066)	(0.081)	(0.135)

Bed Capacity	0.047**	0.051**	0.038**	−0.060**	−0.020**	−0.002**	0.001	0.000
	(0.003)	(0.003)	(0.004)	(0.008)	(0.003)	(0.001)	(0.001)	(0.001)
Population (no. of AMI Patients)	−0.042**	−0.040**	−0.024**	−0.018	0.005	0.008**	0.000	−0.012**
	(0.006)	(0.006)	(0.007)	(0.016)	(0.006)	(0.002)	(0.002)	(0.003)
Effects of Competition and Hospital Characteristics for High-risk Patients								
Very Concentrated Hospital Market	−1.235**	−1.385**	−2.649**	2.974**	0.933**	−0.135	−0.592**	0.822**
(Top Quartile of HHIs)	(0.619)	(0.619)	(0.680)	(1.536)	(0.580)	(0.156)	(0.191)	(0.319)
Concentrated Hospital Market	−1.512**	−1.683**	−2.325**	4.593**	1.263**	−0.233**	−0.349**	0.486**
(Middle Two Quartiles of HHIs)	(0.446)	(0.447)	(0.491)	(1.107)	(0.418)	(0.112)	(0.138)	(0.230)
Above Median Density of	−0.103	0.272	−1.297**	−5.677**	−2.261**	0.132	−0.198	0.439**
Large Hospitals [Median = 0.220]	(0.426)	(0.426)	(0.468)	(1.056)	(0.399)	(0.107)	(0.132)	(0.220)
Above Median Density of	−1.498**	−1.827**	0.716	8.484**	2.838**	0.008	0.055	0.166
For-profit/Nonprofit [Median = 0.012]	(0.442)	(0.442)	(0.486)	(1.096)	(0.414)	(0.111)	(0.137)	(0.228)
Above Median Density of	1.264**	1.522**	−0.588	−2.190**	−0.500	0.096	−0.029	0.334
Public/Nonprofit [Median = 0.029]	(0.411)	(0.411)	(0.452)	(1.020)	(0.385)	(0.104)	(0.127)	(0.212)
Above Median Density of	1.428**	1.167**	1.358**	8.788**	2.843**	0.329**	0.489**	−0.374*
Teaching Hospitals [Median = 0.141]	(0.385)	(0.386)	(0.434)	(0.956)	(0.361)	(0.097)	(0.119)	(0.199)
Above Median Density of	−2.880**	−3.153**	−1.607**	7.605**	2.401**	0.012	0.046	0.208
System Hospitals [Median = 0.525]	(0.327)	(0.327)	(0.359)	(0.811)	(0.306)	(0.082)	(0.101)	(0.169)
Bed Capacity	0.058**	0.066**	0.037**	−0.159**	−0.051**	−0.004**	−0.002	0.000
	(0.004)	(0.004)	(0.004)	(0.010)	(0.004)	(0.001)	(0.001)	(0.002)
Population (no. of AMI patients)	−0.047**	−0.052**	0.025**	0.131**	0.054*	0.015**	0.015**	−0.012**
	(0.007)	(0.007)	(0.008)	(0.018)	(0.007)	(0.002)	(0.002)	(0.004)

Note: All coefficients multiplied by 100 to facilitate interpretation, so coefficients from regressions in logarithms represent approximate percentage changes, and coefficients from outcome models represent percentage point changes. Estimates also control for five-digit zip code fixed effects. $N = 1,736,167$.

competition, then, expands the high-risk versus low-risk difference in expenditures by almost one-third (on a base of 8.3% in 1996, Table I). In competitive markets, the difference in mortality between high-risk and low-risk patients is 0.60 percentage points lower (=−0.822 − (−0.221)) than in uncompetitive markets. In this context, competition shrinks the high-risk versus low-risk difference in mortality by approximately 4% (on a base of 14.7 percentage points in 1996, Table I). However, these extra survivors may be in marginal health: rates of readmission with cardiac complications are significantly higher in competitive hospital markets. This qualification should be interpreted with some caution, because readmission rates measure health outcomes only imperfectly: they represent a combination of the effect of competition on health and the effect of competition on hospital utilization conditional on health.

Other market characteristics affect both quality and expenditures. Most importantly, patients from areas with a high density of teaching hospitals have better health outcomes, regardless of their health status on admission. Low-risk patients from high-teaching-hospital areas have 0.37 percentage points lower mortality, and no higher rates of readmission with cardiac complications; high-risk patients from these areas have approximately the same mortality advantage, although they do suffer from higher complication rates. For low-risk patients, this quality advantage is achieved without any increase in expenditures; for high-risk patients, it is associated with an approximately 1.6% increase in total expenditures.

Hospital ownership affects medical expenditures, but not quality of care. For both high-risk and low-risk patients, areas with an above-median density of public hospitals provide more acute but less non-acute care; conversely, areas with an above-median density of private for-profit hospitals provide more non-acute but less acute care.

Areas with a high density of large hospitals provide more acute care to low-risk patients, but less acute (as measured in days) and less non-acute care to high-risk patients. For high-risk patients, this hospital-size-induced reduction in care has important outcome implications—0.44 percentage points higher mortality. Areas with a high density of system hospitals provide both less acute and less non-acute care to low-risk patients, but less acute and more non-acute care to high-risk patients. For low-risk patients, this hospital-system-induced reduction in care has small but statistically significant outcome implications—0.15 percentage points higher rates of readmission with heart failure.

These estimated effects of competition and other market characteristics are not simply due to market size. The models underlying the estimates in Table II control for both area bed capacity and population. Estimates of the effects of capacity and population are consistent with earlier work (Kessler and McClellan, 2000), which finds that higher levels of bed capacity per patient (approximately equal to the difference between the coefficients on capacity and population from Table II) lead to significantly higher levels of expenditures, lower rates of cardiac complications, and higher rates of mortality.

5. Conclusion

Assessing the role of vertical differentiation in markets for hospital services is an important special case of a difficult general problem in industrial organization. Economic theorists have developed numerous models of the effects of competition on the distribution of qualities in a market, but the conclusions of these models are extremely sensitive to their underlying assumptions. More recently, empirical researchers have begun to investigate the consequences of competition for variety generally (see the literature review in Berry and Waldfogel, 2003), but data limitations have made explicit welfare conclusions difficult (with some important exceptions, such as Berry and Waldfogel, 1999). Because objective measures of health outcomes, such as mortality, are available in observational databases, markets for health care provide an ideal case for study of this issue.

In this paper, we investigate the effects of competition on the level and dispersion of quality and expenditures with longitudinal data on virtually all nonrural elderly fee-for-service Medicare beneficiaries with a new occurrence of a heart attack (AMI) in 1985–1996. Our measure of dispersion is the difference in quality and cost between patients who have different severities of illness, and hence different valuations of quality, but are otherwise demographically and locationally similar. We separate patients into a low-risk or low-valuation and a high-risk or high-valuation group based on the presence of acute care hospital utilization in the year prior to AMI (approximately 30% of elderly AMI patients have prior-year hospital utilization); we control for patient characteristics, the characteristics of area hospital markets, and area-fixed effects.

We find that low-risk patients in competitive markets receive less intensive treatment than in uncompetitive markets, but have statistically similar health outcomes. In contrast, high-risk patients in competitive markets receive more intensive treatment than in

uncompetitive markets, and have significantly better health outcomes. Because this competition-induced increase in variation in expenditures is, on net, expenditure-decreasing and outcome-beneficial according to the estimates in Table II,[3] we conclude that it is welfare-enhancing.

These findings are inconsistent with conventional models of vertical differentiation, although they can be accommodated by more recent models. In conventional models, firms try to relax price competition though differentiation. This implies that oligopoly hospitals lower the quality of care for low-valuation patients in order to be able to charge their high-valuation counterparts more, leading uncompetitive markets in general to have greater variation in quality and expenditures. But empirically, oligopoly hospitals offer a lower quality of care for high-risk patients at lower cost, and offer their low-risk patients roughly the same quality at higher cost, leading uncompetitive markets to have less variation in quality and cost.

The intuition in Anderson and De Palma (2001) explains how oligopoly could lead to lower levels of quality without an increase in its dispersion. Suppose that all hospitals were high-quality, and that this were optimal. If one hospital switched to being low-quality, both its revenues and costs would decline, but the remaining high-quality firms would raise their prices in the sub-game equilibrium, because of the decrease in competition. This secondary effect increases the low-quality hospital's profits because low- and high-quality goods are substitutes. Because the decline in the profits of the switcher would be smaller than the social loss, it may be profitable to switch, even though it is not optimal. Because the same argument applies to all remaining firms, the level of quality could decline without an increase in its dispersion.

Our results support a policy of strict antitrust enforcement in hospital markets. We find no evidence of a welfare downside to competition through increased wasteful treatment variation, as some theoretical models suggest. In addition to confirming that competition is socially beneficial on average (e.g., Kessler and McClellan, 2000), we find no evidence that competition generates aggregate benefits at the expense of a subsample of patients.

If anything, bias due to endogeneity in our measure of illness severity—whether the patient had prior-year utilization—would lead us to the opposite conclusion. To the extent that competition affects utilization before the onset of illness the same way it affects post-onset utilization, higher levels of utilization in uncompetitive markets would

3. Based on 1996 average total hospital expenditures of (Table IB), more concentrated markets lead to expenditure increases (decreases) of approximately $274 per low-risk (high-risk) patient (274 = 0.013 * 21,070 = 0.012 * 22,827), which implies an aggregate expenditure increase of approximately $110 per patient (110 = 0.7 * 274 − 0.3 * 274).

lead marginally low-risk patients to be reclassified as high-risk (because they would be more likely to experience utilization in the year prior to their AMI). In this case, both low-risk and high-risk patients would appear to have better outcomes in uncompetitive markets.

Other market characteristics also affect variation in treatment, and in turn welfare, in hospital markets. The presence of for-profit hospitals in a market, for example, leads to market-wide reductions in various measures of the average level of treatment intensity, but no significant aggregate or differential (between high-risk and low-risk patients) increases in rates of adverse health outcomes. How competition and other market characteristics interact to affect variation in cost and quality, in a model with both horizontal and vertical differentiation, is an important topic for further study. Our results also suggest that some caution may be warranted in the policy debate over variation in medical care. At least for the portion of variation due to competition, variation in quality and cost across patients is socially beneficial.

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THE JOURNAL OF INDUSTRIAL ECONOMICS 0022-1821
Volume XLIX March 2001 No. 1

THE COMPETITIVE EFFECTS OF NOT-FOR-PROFIT HOSPITAL MERGERS: A CASE STUDY*

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Applying conventional horizontal merger enforcement rules to nonprofit hospitals is controversial. Critics contend that the different objective function of not-for-profits entities should mitigate competitive concerns about mergers involving nonprofit hospitals. We analyze a merger that reduced the number of competitors (both nonprofit) in the alleged relevant market from three to two. We find that the transaction was followed by significant price increases; we reject the hypothesis that these price increases reflect higher post-merger quality. This study should help policymakers assess the validity of current merger enforcement rules, especially as they apply to not-for-profit enterprises.

I. INTRODUCTION

ALTHOUGH RESEARCHERS have made innumerable attempts to analyze the relationship between competition (as proxied by concentration) and performance (e.g., price), empirical evidence on the actual competitive effects of horizontal mergers is scarce. Perhaps this is not surprising. When assessed by contemporary antitrust standards, most mergers (even most horizontal mergers) do not present a serious risk of competitive harm. The handful that do typically either will be blocked in their entirety, or approved conditional on the completion of some remedial action (e.g., the divestiture of a critical competitive asset to a third party) designed to ameliorate the risk of competitive harm. Hence, candidates for the study of (plausibly) anticompetitive mergers will arise only infrequently; when, for example, the enforcement agencies lose a merger challenge in court, obtaining no competitive relief, or when the enforcement agencies do not challenge a transaction for reasons unrelated to the transaction's perceived competitive effects.

* This article reflects the views of the authors, not those of Charles River Associates, the Federal Trade Commission, or any individual Commissioner. We thank Severin Borenstein, Denis Breen, Dan Hosken, Paul Pautler, Dave Reiffen, Lou Silvia, John Simpson, and participants in the FTC seminar series, for helpful comments. Kelly Flynn and Sara Harkavy provided excellent research assistance. Remaining errors are ours.

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This paper takes advantage of one of these rare opportunities.[1] We provide an econometric analysis of a horizontal merger in a concentrated hospital market, Dominican Santa Cruz Hospital's acquisition of its sole rival in the city of Santa Cruz, California, AMI-Community Hospital. According to the FTC, only two competitors—both not-for-profit—remained in the relevant market after the transaction.[2] Absent substantial efficiencies, or a credible threat of entry, standard antitrust analysis would predict that an increase in concentration of this magnitude likely would lead to higher equilibrium prices for both competitors. Consequently, this transaction would have been challenged by the FTC, had the Commission been able to intervene before the transaction was completed.[3] However, because the transaction was too small (in absolute size) to trigger the Hart-Scott-Rodino filing thresholds, the FTC did not receive prior notification of the transaction, and the parties were able to consummate the acquisition before the FTC could seek a preliminary injunction. Ultimately, the FTC entered into a consent order with Dominican Hospital, but the decree required only that Dominican notify the Commission prior to any further acquisitions in the relevant geographic market—it did not restore the premerger market structure. For this reason, this acquisition provides an excellent opportunity to assess, *ex post*, the actual, as opposed to the predicted, competitive consequences of a horizontal merger.

This study should be of interest for at least two reasons. First, as noted, empirical studies of the price effects of horizontal mergers are comparatively rare, notwithstanding their apparent importance to appraising the efficacy of federal merger enforcement policy. Studies such as this should help policymakers assess whether the enforcement decision rules embodied in the *Merger Guidelines* predict with an acceptable degree of accuracy the competitive consequences of actual horizontal mergers.

Second, and more specifically, the applicability to hospital markets of the antitrust agencies' approach to horizontal merger analysis (i.e., the *Merger Guidelines*) recently has been called into question. A substantial share of hospital output (approximately 90%) is produced by private and public nonprofit hospitals. Critics have contended that the antitrust agencies and courts have assumed that these not-for-profit providers seek maximum profits, notwithstanding the substantial body of theoretical and

[1] Both the Federal Trade Commission and the Department of Justice have unsuccessfully challenged other horizontal hospital mergers. However, these transactions are less amenable to empirical analysis than the Dominican Santa Cruz-Community merger because (1) the transactions are too recent to allow measurement of post-merger market performance, and/or (2) reliable price data do not exist.

[2] See Complaint *In the Matter of Santa Cruz Hospital, et al.* 118 F.T.C. 382 (1994).

[3] See Statement of Chairman Janet D. Steiger in Support of Final Issuance of Consent Order *In the Matter of Dominican Santa Cruz Hospital, et al.* 118 F.T.C. 382 (1994).

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empirical analyses suggesting that nonprofit entities—or more specifically, certain types of nonprofit entities—will eschew opportunities to profitably exercise market power.[4] For example (see Lynk [1995], pp. 440–41), it is conceivable that a private nonprofit hospital sponsored and administered by the local community, might function something like a consumer cooperative. If so, the incentives of producers and consumers would be aligned, and any incentives the hospital might otherwise have to raise prices anticompetitively would be attenuated. Alternatively, the behavior of a nonprofit hospital whose profits are used to fund some particular set of activities valued by the firm's managers—e.g., providing charity care to the poor—might be indistinguishable from that of an identically situated for-profit entity.

Whether the (potentially) different incentive structure of not-for-profit hospitals could attenuate the exercise of market power is of more than just academic interest. The courts that must adjudicate horizontal merger challenges also have found such arguments compelling. In at least one case,[5] a US Federal District Court found that the nonprofit, community-sponsored status of the merging parties was an important factor in rebutting an otherwise convincing *prima facie* case against the merger of two rival hospitals.

The transaction analyzed here provides an excellent opportunity to explore these possibilities. The acquiring entity (Dominican Santa Cruz Hospital) is part of a chain of Catholic hospitals operating in the western United States. Its sole remaining rival in Santa Cruz county, Watsonville Community, is a locally-sponsored community hospital. According to the arguments set forth above, Watsonville Community would appear to be the type of nonprofit hospital least prone to exercise market power; any such propensity to charge competitive prices would, moreover, place a powerful post-merger competitive constraint on Dominican's ability to raise prices. Consequently, an analysis of both entities' post-merger pricing behavior should provide a valuable insight into the behavior of nonprofit producers.

II. PREVIOUS STUDIES OF HOSPITAL COMPETITION

Many studies of hospital competition have been carried out using a variant of the 'Structure-Conduct-Performance' (S-C-P) paradigm. Early (i.e., pre-1983) studies frequently found a *negative* relationship between hospital

[4] See Lynk [1995] for a more detailed review of the relevant theory and evidence.

[5] See *F.T.C. v. Butterworth Health Corporation and Blodgett Memorial Medical Center* (US District Court, Western District of Michigan, Southern Division), September 26, 1996, slip. op. at 27.

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concentration and costs,[6] which usually was interpreted as evidence of insurance-induced moral hazard. Studies using data from the mid–1980s and after typically found a *positive* relationship between concentration and price.[7]

While suggestive, these price-concentration studies do not provide direct evidence of the effects of hospital mergers. One problem with drawing inferences about the competitive effects of mergers from this literature is that the results are almost surely sensitive to the way the geographic markets are defined, since this definition will determine the value of the concentration index.[8]

An alternative empirical strategy for assessing the consequences of merger-induced changes in market structure is to examine directly, through a comparison of the pre- and post-merger prices charged by the merged entity (and, perhaps, its plausible rivals). This 'event study' approach obviates the necessity of defining the 'relevant market.' If the merger creates market power, then (after suitably controlling for other possible shifts in the exogenous determinants of price) one should observe the merged entity raising its price post-merger. It is unnecessary to identify the relevant market to carry out this test—at minimum, one requires only data for the merged entity.

Early applications of the event study method (e.g., Barton and Sherman [1984]; Kim and Singal [1993]) used a relatively simple specification: they analyzed movements in the price of the product affected by the merger, relative to the price of a substitute product hypothesized to face similar demand and cost conditions, but unaffected by the merger. The equality of pre- and post-merger prices was then tested using a simple t test. Later implementations of the event study method (e.g., Schumann *et al.* [1992, 1997]) used a somewhat different approach—they estimated a price equation with data spanning the pre- and post-merger periods.[9] The competitive effect of the transaction was captured with a dummy variable set equal to one for the post-merger period. This method is potentially problematic if there are unobserved exogenous determinants of price that are correlated with the merger dummy. If so, the merger coefficient would reflect the competitive effects of the transaction, as well as movements in

[6] For a comprehensive review of this literature see Pautler and Vita [1994]. For seminal works see Joskow [1980] and Robinson and Luft [1985].

[7] See, e.g., Dranove *et al.* [1993]; Melnick *et al.* [1992]; Keeler, Melnick and Zwanziger [1999]; and Simpson and Shin [1998].

[8] For example, see Keeler and McClellan [1999] and Werden [1989]. Only the former have offered an alternative method for defining antitrust markets. Although there seldom may be good practical alternatives to patient flow data, it is nonetheless true that antitrust markets defined on this basis may lead to incorrect conclusions about the competitive constraints faced by a particular pair of merging hospitals.

[9] The control variables consisted of demand and cost shifters.

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these unobserved price determinants, leading one to incorrectly estimate the price effects of the transaction.

Below, we propose an empirical framework that combines elements of the Barton and Sherman, and Schumann *et al.* approaches. We believe that this strategy will provide the best method for identifying accurately the competitive effects of the acquisition. Before setting forth this empirical strategy, we first describe in greater detail the events of the Dominican-Santa Cruz transaction.

III. HISTORY OF THE TRANSACTION

On March 8, 1990, Dominican Santa Cruz Hospital ('Dominican'), a 259-bed, not-for-profit hospital, affiliated with the Catholic Healthcare West system, purchased the only other hospital in the city of Santa Cruz, AMI-Community Hospital ('Community'). Community, which was affiliated with American Medical International, was licensed for 180 beds and was a for-profit entity. Dominican and Community were located about two miles apart. Five months after the acquisition (August 1990), Community was converted completely to a nursing home/rehabilitation facility. The only other hospital in Santa Cruz county was Watsonville Community Hospital, located about 14 miles south of the city of Santa Cruz. The city of Santa Cruz is located about 40 miles south of San Jose, and 80 miles south of San Francisco. Santa Cruz county is bordered on the south and west by the Pacific ocean, and on the north and east by the Santa Cruz mountains.

Contemporaneous data on patient flows showed that the overwhelming majority (about 94%) of the three Santa Cruz county hospitals' patients resided in Santa Cruz county, and that most (about 97%) Santa Cruz residents receiving inpatient hospital care received it from hospitals in that county.[10] The patient flow data also showed that very few—less than 2.5%—of the patients at the next closest set of competitors originated in Santa Cruz county.[11] In short, there was very little evidence to suggest that residents of Santa Cruz county regarded out-of-county hospitals as good substitutes for in-county hospitals, or that Santa Cruz county hospitals sought to attract patients from outside of the county. Accordingly, the FTC's complaint alleged that the relevant geographic market was 'Santa Cruz County and/or portions of Santa Cruz County.' Only two

[10] Nine Santa Cruz county ZIP codes account for over 80% of the privately insured inpatients at the two hospitals.

[11] The next closest competitors (Community Hospital of Los Gatos and Good Samaritan Hospital) were both located in Los Gatos (Santa Clara County). Both hospitals were approximately 25 miles (41 minutes driving time) from Dominican Santa Cruz Hospital. Watsonville Hospital, by contrast, was only 14 miles from Dominican (23 minutes driving time).

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hospitals—Dominican and Watsonville Community—remained in this market post-merger. According to the Complaint, the merger increased the market share (of patient-days) of Dominican from 62% to approximately 73%, and increased the market share (of available beds) from 50% to 73%. The Herfindahl-Hirschman Index for the relevant antitrust market increased by over 1,700 points (from approximately 4,620 to approximately 6,350) when measured by patient-days; and by over 2,300 points (from approximately 3,770 to approximately 6,090) when measured by available beds. Under the *Merger Guidelines* enforcement criteria, a transaction generating concentration figures of this magnitude would be presumed anticompetitive. Absent compelling evidence that such a merger would create substantial efficiencies, or that the exercise of market power would be constrained by the threat of entry, normally the FTC would seek to preliminarily enjoin such a transaction.[12] Had the FTC had the opportunity to seek a preliminary injunction in this case, it would have done so.[13] However, as noted earlier, the small absolute size of the transaction failed to trigger the Hart-Scott-Rodino filing thresholds, and the FTC was not able to seek an enforcement action until after the transaction was completed.

In March, 1993, approximately three years after the merger was consummated, the FTC accepted a consent agreement with Dominican Santa Cruz Hospital and Catholic Healthcare West. The consent order did nothing to restore the pre-merger competitive environment; it required only that the respondents obtain the Commission's prior approval before acquiring any other hospitals in Santa Cruz County. Although all of the FTC Commissioners concluded that the merger probably had created significant market power, a majority of the FTC Commissioners concluded that the agency had few good remedies available to it.[14] The acquired hospital, Community, already had been converted to a skilled nursing/rehabilitative care facility. Thus, the effects of the merger could have been reversed only at considerable cost. Further, Sutter Health, a major Northern California hospital chain, had announced plans to construct an acute care hospital in Santa Cruz, and had already purchased a 3.8 acre

[12] According to the 1992 *Merger Guidelines* (§0.51(c)), 'the [FTC] regards markets [with HHIs above 1800] to be highly concentrated . . . [when] the post-merger HHI exceeds 1800, it will be presumed that mergers producing an increase in the HHI of more than 100 points are likely to create or enhance market power or facilitate its exercise.'

[13] As then-FTC Chairman Steiger observed at the time, '[t]he facts of this case provide sufficient reason to believe that this acquisition violates Section 7 of the Clayton Act. Ordinarily, such facts would lead the Commission to seek a preliminary injunction in federal district court.' See Statement of Chairman Janet D. Steiger in Support of Final Issuance of Consent Order *In the Matter of Dominican Santa Cruz Hospital, et al.* 118 F.T.C. 382 (1994).

[14] See Statements of Chairman Steiger, Commissioner Azcuenaga, and Commissioner Yao *In the Matter of Dominican Santa Cruz Hospital, et al.* 118 F.T.C. 382 (1994).

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site toward that end.[15] The FTC reasoned that entry by this entity likely would already have occurred by the time divestiture could be completed, thereby moving the market closer to the pre-merger status quo more rapidly than could be accomplished through the FTC's administrative process. As it turned out, some time in the second quarter of 1996, Sutter Health opened the Sutter Maternity and Surgery Center with 30 licensed and 21 staffed beds.

IV. EMPIRICAL ANALYSIS: METHODS AND DATA

IV(i). *Basic Price Regressions*

We begin our empirical analysis by first presenting some basic descriptive information on the behavior of prices at the two remaining Santa Cruz county hospitals. Our measure of price is derived from data supplied by the Office of Statewide Health Planning and Development (OSHPD). For each quarter (1986 through 1996, inclusive) we calculate the average net revenue received per inpatient acute-care admission (or, alternatively, per patient day[16]) for privately insured patients.[17] Of course, hospitals provide numerous inpatient services, some of which may or may not be demand- or supply-side substitutes. Nevertheless, a single measure of inpatient price is consistent with the so-called 'cluster' approach to defining hospital product markets used in virtually all hospital merger investigations.[18]

[15] *Sacramento Business Journal*, March 16, 1992.

[16] All of the estimates carried out with dependent variables defined as per-day values are available at the *JIE* Editorial website.

[17] In the OSHPD data, there are various categories for both gross and net patient revenue. Net revenue is equal to a hospital's gross revenue *minus* any discounts that it offers. In the data, the *gross* revenue figures distinguish between inpatient and outpatient revenue, however, the *net* revenue figures do not. As noted by Dranove *et al.* 1993], failure to account for discounts seriously understates the effect of competition on price. Thus, several adjustments must be done in order to obtain estimates of net inpatient revenue from the gross inpatient data. While OSHPD has been collecting quarterly data from hospitals since approximately 1980, data prior to 1986 did not in any way distinguish revenue by payer group. As a result, observations from prior to 1986 were eliminated. For data from 1986 to 1992, net inpatient price was calculated by multiplying total net revenues from non-Medicare, non-Medicaid patients by the ratio of gross *inpatient* revenue to gross *total* revenue at the hospital. While this net revenue figure eliminates Medicare and Medicaid patients it does include revenue from some patients in various non-Medicaid indigent programs. This net revenue figure is then divided by discharges to obtain the average price paid per non-Medicare, non-Medicaid acute-care inpatient. We also adjusted the number of discharges by the ratio (total revenue-bad debt/total revenue) in order to account for bad debt.

For data after 1992, patient revenue for various indigent programs is reported in a separate category. In order to keep the observations consistent over time, revenue from this category was added to the revenue figures for commercially insured patients. Net price was then calculated using the same methodology as outlined for the 1986 to 1992 data.

[18] For a critical overview of the 'acute care inpatient' product market definition used in hospital merger investigations, see Sacher and Silvia [1998].

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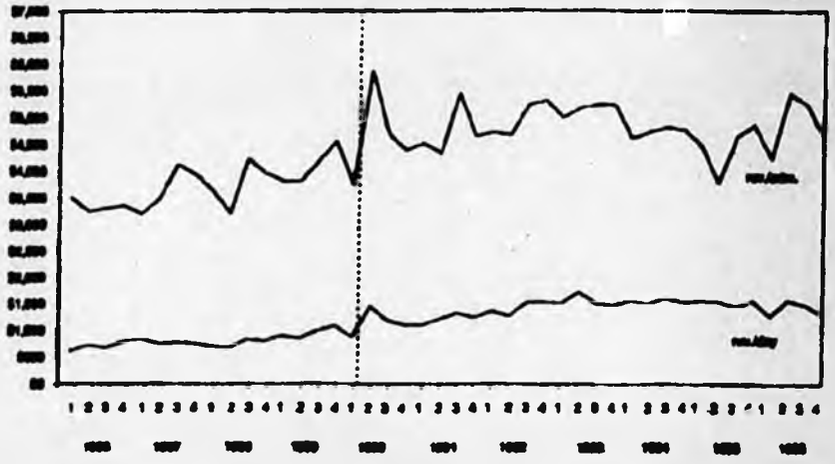


Figure 1
Quarterly Real Price per Admission and per Inpatient Day Dominican Hospital

It should be noted that the price series in Figure 1 does not include information on Community's prices. Normally, we would like to assess the competitive effects of a merger by examining the pre- and post-merger prices of both transaction partners. Unfortunately, that approach is not feasible here because Community was converted to a nursing home/rehab center shortly after the acquisition, and no post-transaction price data are available for it.[19] We have concluded, therefore, that the best available test of the impact of removing this competitive constraint on Dominican's pricing discretion is obtained from comparing Dominican's pre- and post-merger prices; accordingly, the regression results reported in Table III below are based on this comparison. However, to assess the robustness of these results, we also carried out all of regression analyses presented in Table III using (pre-merger) dependent and explanatory variables redefined as weighted averages of the values for Dominican and Community. Our principal findings are robust to this modification.[20]

Figures 1 and 2 depict the behavior of per-day and per-admission prices at Dominican and Watsonville hospitals for the entire sample period. The dashed vertical line indicates the quarter in which the merger occurred. Visual inspection of these series suggests that while there was an upward trend in real prices predating the transaction, prices did increase

[19] The conversion was completed by August 1990. OSHPD ceased reporting separate data for Community after the 1st quarter of 1990.

[20] We experimented with weights based on patient days, patient discharges, and inpatient revenue. All produced essentially the same results. The results reported at the *JIE* Editorial website are derived using inpatient revenue weights.

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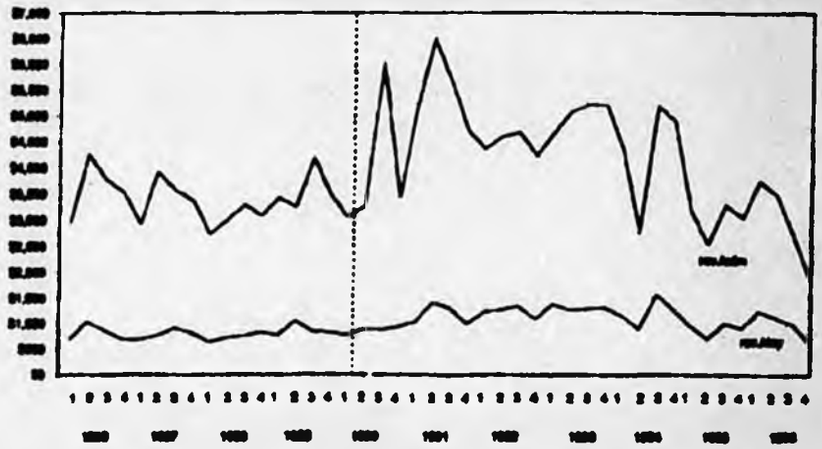


Figure 2
Quarterly Real Price per Admission and per Inpatient Day Watsonville Hospital

in the transaction's aftermath. This assessment is supported by the regression results reported in column (a) of Tables III and IV. Here we present simple regressions of price (real net revenue per admission) on a merger dummy variable (merge) and a time trend (time and time-squared).[21] These regressions suggest a substantial post-merger price increase at both Dominican and Watsonville, on the order of $700 and $1,800 respectively, even when the time trend is controlled for explicitly. We reject the null hypothesis of no merger effect at all conventional significance levels.

While the results contained in Tables III and IV are consistent with a merger-induced increase in price, obviously the simple specification on which they are based will fail to control for many of exogenous determinants of equilibrium prices (except to the extent that they follow a linear-quadratic time trend). If these omitted factors are correlated with merge we will improperly impute their effect to the merger. Similar to Schumann *et al.* (1992, 1997), we next attempt to estimate a more fully specified reduced form price equation.

IV(ii). *Reduced Form Price Equations*

To ensure that the observed price effect of the merger is not merely the

[21] As noted previously, all of the equations reported in the paper also have been estimated with the dependent variable computed on a per-inpatient day basis. In the fully specified version of the price equations, we find that the statistical significance of the coefficient on merge falls in the Dominican equation ($p = 0.18$), but increases in the Watsonville equation ($p = 0.07$).

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result of omitted variable bias, it is necessary to control for factors that likely will affect the behavior of prices both over time and across hospitals. It is clear that the unit of output employed in this study—an inpatient discharge or inpatient day—is nonhomogeneous. Patient stays can and do vary substantially in terms of their resource intensity. Consequently, cross-sectional and intertemporal comparisons of the 'price' of this output are meaningless unless one controls somehow for this heterogeneity.

We employ several such controls. First, like other researchers (e.g., Simpson and Shin [1998]), we construct an index of hospital 'casemix.' The Healthcare Financing Administration (HCFA) assigns a 'caseweight' to each diagnostic related group (DRG).[22] This index measures the 'resource intensity,' used, on average, for each DRG relative to other DRGs and over time. The OSHPD discharge data set includes the date of discharge and DRG for each patient. Using these data, we created a quarterly casemix indicator for each hospital used in the empirical analysis. This was done as follows. Each non-Medicare/non-Medicaid discharge at each hospital for each quarter was weighted using the HCFA caseweight index for the relevant DRG. The weighted discharges were then summed and divided by the total number of discharges for each quarter at each hospital to obtain the casemix index.

As a further control for discharge heterogeneity, we also include the average length-of-stay for privately insured patients. The rationale for including this measure is straightforward—each additional day of hospitalization requires the consumption of additional labor and material resources. One cannot compare the price of a discharge across different time periods, or across different hospitals, unless one controls for variations in length-of-stay.

Equilibrium hospital prices also will be affected by exogenous changes in factor prices. We include two variables to control for these shifts. First, HCFA computes a wage index for all urban areas (a county or set of counties) based on the salaries and wages of various health care workers in the relevant locale. This index is used to adjust hospital payments under the Prospective Payment System (PPS) for Medicare. As an additional control variable, we include the BLS Producer Price Index for surgical and medical instruments and apparatus.

It is well-established empirically that the growth of managed care institutions (e.g., HMOs, PPOs) has facilitated more intense price competition among hospitals (e.g., Dranove, Shanley, and White [1993]; Kralewski *et al.* [1992]), as well as greater productive efficiency. Consequently, other things equal, we would expect to observe lower prices

[22] DRGs refer to a system of classifying patients based on medical diagnoses and surgical procedures. Originating at Yale University during the 1970s, the DRG system has been widely adopted by payers and providers as a way of classifying patients.

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in markets where selective contracting by managed care organizations is more prevalent. Ideally, we would like to utilize some measure of the market share of managed care institutions in the relevant market. Unfortunately, such data are not readily available. As a proxy, we calculate for each hospital the percentage of total discharges for which the expected payment source is an HMO or other prepaid health plan.[23]

Similar to other empirical studies of hospital mergers (e.g., Lynk [1995], Simpson and Shin [1998]), we include a number of other variables to control for exogenous demand- and cost-side variation. These consist of per capita income, the county-level unemployment rate, county population density, share of admissions covered by Medicare, share of admissions covered by MediCal, and the Producer Price Index for medical and surgical equipment.

Last, we also control for the effects of the October 1989 northern California earthquake, which may have reduced (exogenously) Watsonville's productive capacity, leading to higher prices for reasons unrelated to the Dominican transaction. To capture the competitive effects of this event, we create a dummy variable (quake) equal to 1 for the 4th quarter of 1989 and all subsequent periods, and 0 otherwise. We also include a dummy variable (entry) indicating the entry of the small (21 bed) Sutter hospital in 1996.

We note that the earthquake dummy variable is potentially problematic for us, since it is highly collinear with the merger dummy. Essentially, there are only two quarters of data (1989:Q4–1990:Q1) that differentiate these two variables. This may make it difficult to estimate the respective effects of these two events on price with any precision.[24] That said, there are reasons to doubt that the quake actually had an economically significant impact on Watsonville's productive capacity. Whether measured by total patient days or total discharges, the OSHPAD data suggest that Watsonville's output actually increased in the aftermath of the quake.[25]

Column (b) of Tables III and IV presents the reduced form price regressions for Dominican and Watsonville, respectively. In the case of

[23] We recognize that this managed care index quite plausibly is an endogenous variable jointly determined with our price variable; as a consequence, its inclusion could induce simultaneous equations bias in our estimated coefficients. Accordingly, we estimate our equations both with and without this variable. None of our results are sensitive to this change in specification. These results are reported in full at the *JIE* Editorial website.

[24] We note, however, that in the several of the Watsonville regressions, the coefficients on both merge and quake are individually significant, suggesting that there is sufficient variation in the sample to accurately estimate both parameters.

[25] A regression of total patient days against a time trend and the quake dummy yields a coefficient on quake of 803.51 (s.e. = 480.65). A similar regression using total discharges yields a coefficient (standard error) on quake equal to 53.18 (182.24) The full regression results are available at the *JIE* Editorial website.

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Dominican, adding these additional explanatory factors to the reduced form price equations leaves the coefficient on merge essentially unchanged (it actually increases slightly, from $696/admission to $749/admission), but it does increase the standard error of the estimate, from $169 to $474. The corresponding t statistic (1.61) leads one to reject the null hypothesis of no merger price effect at the $p = 0.12$ significance level. For Watsonville,

TABLE I
VARIABLE DEFINITIONS

Variable Name	Description
rprice_d	real net revenue per private admission, Dominican Hospital
rprice_w	real net revenue per private admission, Watsonville Hospital
rprice_p	real net revenue per private admission, peer group hospitals
rpday_d	real net revenue per private day, Dominican Hospital
rpday_w	real net revenue per private day, Watsonville Hospital
rpday_p	real net revenue per private day, peer group hospitals
expadm_d	real expense per admission, Dominican
expadm_w	real expense per admission, Watsonville
expadm_p	real expense per admission, peer group hospitals
expday_d	real expense per inpatient day, Dominican
expday_w	real expense per inpatient day, Watsonville
expday_p	real expense per inpatient day, peer group hospitals
length-of-stay_d	average length-of-stay, Dominican Hospital
length-of-stay_w	average length-of-stay, Watsonville Hospital
length-of-stay_p	average length-of-stay, peer group hospitals
medi-Cal share_d	share of admissions MediCal, Dominican Hospital
medi-Cal share_w	share of admissions MediCal, Watsonville Hospital
medi-Cal share_p	share of admissions MediCal, peer group hospitals
medicare share_d	share of admissions Medicare, Dominican Hospital
medicare share_w	share of admissions Medicare, Watsonville Hospital
medicare share_p	share of admissions Medicare, peer group hospitals
casemix_d	casemix index, Dominican
casemix_w	casemix index, Watsonville
casemix_p	casemix index, peer group hospitals
popdensity_p	population density, peer group counties
popdensity_s	population density, Santa Cruz County
hmo_d	share of admissions HMO insured, Dominican
hmo_w	share of admissions HMO insured, Watsonville
hmo_p	share of admissions HMO insured, peer group
income_s	real per capita income, Santa Cruz County
income_p	real per capita income, peer group counties
ppi_med	producer price index, medical and surgical instruments
unemploy_p	unemployment rate, peer group counties
unemploy_s	unemployment rate, Santa Cruz County
wage_d	HCFA wage index, Dominican
wage_w	HCFA wage index, Watsonville
wage_p	HCFA wage index, peer group
quake	= 1 for 4th quarter 1989 and after, 0 otherwise
merge	= 1 for 2nd quarter 1990 and after, 0 otherwise
entry	= 1 for 2nd quarter 1996 and after, 0 otherwise
time	time trend
timesquared	time trend squared

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estimating the price effect of the merger using the expanded set of regressors reduces the estimated merger effect from $1,843 per admission to $496 per admission. In contrast to Dominicus equation, the standard error on the merge coefficient falls with the addition of these regressors to the equation. In this specification, we reject the null hypothesis of no merger effect at the $p = 0.10$ significance level.

TABLE II
DESCRIPTIVE STATISTICS

Variable Name	Mean	Minimum	Maximum
rprice_d	4434.55	3212.89	5882.0
rprice_w	3897.98	1794.32	6490.128
rprice_p	5088.39	3526.29	8299.39
rpday_d	1192.75	623.53	1730.41
rpday_w	994.16	593.75	1566.64
rpday_p	1242.72	783.33	1626.55
expadm_d	4118.93	3212.4	4986.1
expadm_w	3343.72	2582.8	3969.6
expadm_p	4038.26	3185.02	4628.92
expday_d	719.92	497.07	962.92
expday_w	756.47	581.91	1064.58
expday_p	810.87	554.70	1116.33
length-of-stay_d	4.01	2.71	5.63
length-of-stay_w	3.99	2.71	6.79
length-of-stay_p	4.28	3.53	4.88
medi-Cal share_d	0.14	0.051	0.17
medi-Cal share_w	0.29	0.10	0.48
medi-Cal share_p	0.21	0.17	0.25
medicare share_d	0.39	0.33	0.44
medicare share_w	0.31	0.22	0.40
medicare share_p	0.39	0.36	0.42
casemix_d	0.85	0.75	1.04
casemix_w	0.76	0.67	0.87
casemix_p	0.94	0.84	1.06
popdensity_p	88.55	78.69	95.69
popdensity_s	516.96	486.10	539.57
hmo_d	0.25	0	0.50
hmo_w	0.06	0	0.25
hmo_p	0.13	0.05	0.23
income_s	16104.97	14464.69	17700.51
income_p	13214.04	12892.70	13504.33
ppi_med	121.19	107.27	131.27
unemploy_p	10.46	8.02	14.23
unemploy_s	8.35	5.37	13.83
wage_d	1.22	0.97	1.42
wage_w	1.20	0.97	1.39
wage_p	1.16	1.12	1.23
quake	0.659	0	1
merge	0.63	0	1
entry	0.11	0	1
time	22.5	1	44
timesquared	667.5	1	1936.8

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TABLE III
DOMINICAN HOSPITAL PRICE AND EXPENSE REGRESSIONS
(STANDARD ERRORS* IN PARENTHESES)
Quarterly Data, 1986–96

	net rev./ admission (a)	net rev./ admission (b)	net rev./ admission (difference) (c)	exp./ admission (difference) (d)
merge	696.50‡ (169.31)	749.68 (474.71)	1005.49§ (506.49)	172.74 (139.75)
income		−0.39† (0.12)	−0.16 (0.22)	−0.27‡ (0.07)
popdensity		−5.45 (23.99)	29.86 (34.57)	4.36 (8.45)
unemploy		−72.30† (31.26)	−36.61 (55.09)	16.61 (31.19)
length-of-stay_d		486.26† (177.77)	469.45† (178.71)	39.81 (65.01)
hmo_d		−683.03 (1021.08)	−868.32 (1483.21)	229.97 (652.86)
casemix_d		−1689.06 (1793.83)	1638.76 (1355.49)	−857.21 (908.89)
wage_d		−177.02 (390.12)	−603.42 (905.78)	−616.17† (297.87)
ppi_med		71.25 (70.36)	94.55 (87.17)	−34.73 (38.73)
medicare share_d		3805.44 (2623.12)	5191.34 (3122.95)	−1409.13 (1847.34)
medi-Cal share_d		1076.23 (3032.58)	4752.39 (3579.07)	1581.50 (1862.95)
time	68.60‡ (14.48)	31.19 (88.26)	−170.48 (109.39)	−10.24 (38.01)
timesquared	−1.18‡ (0.25)	−0.54 (1.80)	1.44 (0.96)	0.75† (0.34)
quake		263.89 (290.56)	287.52 (302.42)	407.36‡ (143.69)
entry		634.83† (247.84)	480.23† (219.56)	334.38† (147.97)
intercept	3241.67‡ (120.26)	1110.79 (14136.84)	−21598.48 (19087.31)	2549.66 (5076.65)

*Newey-West heteroskedasticity and autocorrelation consistent standard errors (lag length = 4)
†significant at $p < 0.05$
‡significant at $p < 0.01$
§significant at $p < 0.10$.

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TABLE IV
WATSONVILLE HOSPITAL PRICE AND EXPENSE REGRESSIONS
(STANDARD ERRORS* IN PARENTHESES)
Quarterly Data, 1986–96

	net rev./ admission (a)	net rev./ admission (b)	net rev./ admission (difference) (c)	exp./ admission (difference) (d)
merge	1843.47‡ (433.58)	495.92§ (287.58)	671.83§ (389.48)	79.27 (176.02)
income		−0.54‡ (−0.15)	−0.18 (0.21)	−0.22† (0.08)
popdensity		−103.17‡ (22.03)	−51.67 (40.76)	−38.51† (17.73)
unemploy		0.59 (52.02)	77.21 (90.65)	70.60 (45.63)
length-of-stay_w		765.42‡ (170.76)	527.40† (221.85)	308.64‡ (98.56)
hmo_w		−2681.78 (2922.64)	−834.28 (2823.67)	831.62 (1395.01)
commin_w		7281.31‡ (1655.52)	7529.36† (3318.51)	−676.27 (918.54)
wage_w		−554.65 (1080.64)	−666.00 (1788.47)	178.95 (610.52)
ppi_med		290.81† (110.51)	285.55† (123.90)	81.73 (71.53)
medicare share_w		952.24 (5536.11)	6768.92 (5999.19)	2113.03 (1868.28)
medi-Cal share_w		−3653.65§ (2043.66)	−1089.69 (2238.37)	−1723.45† (648.39)
time	49.74 (33.93)	102.91 (82.25)	−185.62§ (109.71)	−33.61 (45.63)
timesquared	−2.32‡ (0.59)	−2.42§ (1.28)	0.91 (1.40)	0.33 (0.63)
quake		−485.24§ (266.57)	−754.18† (281.97)	−472.89‡ (139.17)
entry		105.66 (404.22)	446.43 (426.99)	−46.91 (121.96)
intercept	3199.53 (304.76)	22894.06 (14053.78)	−7145.13 (18614.65)	7779.72 (6938.94)

* Newey-West heteroskedasticity and autocorrelation consistent standard errors (lag length = 4)
† significant at $p < 0.05$
‡ significant at $p < 0.01$
§ significant at $p < 0.10$.

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IV(iii). *Reduced Form Price Estimates with 'Peer Group' Controls*

Although we have attempted to specify the reduced form price equation as fully as possible, it is questionable whether this specification fully captures all of the exogenous factors that might affect the equilibrium prices of the merged entity and its competitors.[26] To better capture the effects of these factors, and thus estimate more precisely the equilibrium impact of the merger, we incorporate into our empirical approach elements of the Barton and Sherman [1984] and Kim and Singal [1993] merger studies. These studies analyzed movements in the price of the product affected by the merger, conditional on the price of a substitute product believed to have faced similar demand and cost conditions, but which is unaffected by the merger. By so doing, they controlled for otherwise unobserved demand and cost factors, unrelated to the merger, that might influence intertemporal price behavior at the merging entities.

The State of California has undertaken two studies to categorise hospitals into 'peer groups' for purposes of setting Medi-Cal reimbursement levels, the most recent in 1991 (Department of Health Services, [1991]). These studies form the basis for the construction of the control group used here. The peer grouping method used by the State of California first placed specialty, teaching, and prepaid hospitals in their own separate peer groups. The study then used 'cluster' analysis to group rural hospitals and other 'unusual' hospitals (*see* State of California [1991], § 5). After the latter were classified into these peer groups, only urban short term facilities remained. These facilities were then subdivided into peer groups on the basis of licensed bed size. In the 1982 study, Dominican Santa Cruz and Community Hospital of Santa Cruz were placed in the 'moderately-sized' urban category, while Watsonville was placed in the 'small-urban' hospital peer group. In the 1991 study, Dominican Santa Cruz was placed in the 'medium-sized urban' hospital peer group, which consisted of all hospitals not elsewhere classified with between 170 and 270 licensed beds. Watsonville was placed in the 'moderately small- sized' urban hospital peer group, which consisted of all hospitals not elsewhere classified with between 95 and 170 licensed beds.

We used the following procedure to establish a control group for the current study. First, to ensure that peer hospitals were located in markets as similar as possible to the Santa Cruz market, hospitals located in counties that were part of very large Primary Metropolitan Statistical Areas (PMSAs) were eliminated. This eliminated hospitals located in the following counties: Los Angeles, Orange, Ventura, Riverside, San Bernardino, San Diego, San Francisco, Alameda, Contra Costa, Marin,

[26] Several of the control variables (income, popdensity, unemploy, hmo and wage) vary only on an annual, not quarterly, basis.

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San Mateo and Santa Clara. The competitive environment in such large urbanized areas likely is very different from that found in the less urbanized area of Santa Cruz.

Next, the peer group was restricted to those hospitals that were placed in any of the short term urban hospital peer groups in the 1991 California study, and were licensed with between 100 and 300 beds in that year. While somewhat arbitrary, these licensed bed cut-offs would appear to limit the sample to hospitals reasonably comparable to the hospitals in Santa Cruz. This left 41 potential peer group hospitals. We next eliminated those hospitals in this group that were not in the same bedsize category, and/or that did not fall under one of the urban hospital groupings in the 1982 California Peer Group survey. This left 33 potential peer group hospitals. Eight more hospitals were eliminated because (according to the 1996 *AHA Guide*) they did not fall into the appropriate bedsize category. We then eliminated all hospitals that had themselves been involved in a horizontal acquisition as reported in the OSHPD Hospital History Listing database, or were located in a county where a horizontal merger had occurred during the sample period. This group of 16 remaining hospitals constitutes our peer group (*see* Appendix A).

Column (c) of Tables III and IV presents estimates of the reduced form price regressions incorporating the peer group controls. In these equations the dependent and explanatory variables have been redefined as the difference between the own- and peer group value (e.g., in the Dominican equation, the dependent variable equals the Dominican price minus the (mean) peer group price). The results from this specification continue to suggest a fairly large price effect from the transaction ($1,005/admission in the case of Dominican; $672/admission in the case of Watsonville). These estimates are statistically significant at the $p = 0.06$ and $p = 0.10$ levels, respectively.

Many of the other coefficients in this equation have the expected sign, but are not always statistically significant. The coefficient on average length-of-stay (alos_d and alos_w) is positive in both equations, and significant at the $p = 0.02$ level. The medical equipment price index is positive in both equations, as expected, but significant at conventional levels only in the Watsonville equation. Similarly, the estimated parameter on the casemix index is positive and significant only in the Watsonville equation. The HMO share variable is negatively related to price in both equations, as one would expect, but is never significant.

We also observe an interesting pattern of results on the two event variables, quake and entry. In both equations, the coefficient on entry is large and positive; in the case of Dominican, we can reject the null of a zero coefficient at the $p = 0.04$ significance level. Obviously, this is somewhat counterintuitive; one possible explanation is that the entry of Sutter induced Dominican to increase its quality, leading to higher prices

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and higher unit costs. This possibility receives some support from the expense regressions reported in column (d), which show that Dominican's expenses per admission increased by about $263 ($p = 0.08$) when Sutter entered the market. However, the results for the Watsonville equation do not support this hypothesis.

The pattern of coefficients on quake (positive in the Dominican price equation, negative in the Watsonville price equation) can be potentially rationalized as an exogenous quality reduction at Watsonville that allowed Dominican to raise its price. The quake coefficient is not significant in the Dominican equation, however, though it is in the Watsonville equation ($p = 0.06$).

V. ALTERNATIVE EXPLANATIONS FOR THE POST-MERGER PRICE INCREASE

While the empirical results presented in Tables III and IV suggest a post-merger price increase—with the evidence strongest in the case of the merged entity, Dominican—our inability to observe and measure quality perfectly means that we cannot rule out the possibility that the price increases reflect improvements in quality, rather than increased price-cost markups with unchanged (or even diminished) quality levels. The evidence on this possibility is mixed. We observe first that the parties to the acquisition made no such claims in defense of the transaction. If significant quality improvements resulted from the transaction, they were not foreseen by the parties at the time of transaction. Rather, the parties claimed that the efficiencies from the transaction would derive from the realization of scale-related production efficiencies.[27] To the extent that such scale economies were realized, we would expect prices to fall, other things held constant.

It is perhaps conceivable that consolidation of particular services at Dominican could lead to volume-related quality increases—for example, because clinical outcomes for some procedures improve as the procedure is performed with higher frequency at a particular location.[28] Then, Dominican might be able to capture some or all of the value of this quality increase in the form of higher prices.

The problem with this explanation is that it fails to explain the post-merger increase in price at Watsonville Hospital. If the elimination of Community Hospital as a provider of the services in question leads to higher (quality-unadjusted) prices at Dominican because of the efficiencies

[27] See Statement of Commissioner Yao. Dominican claimed that Community Hospital was inefficiently small, and that efficiencies could therefore be realized by converting it to a skilled nursing/rehabilitation facility, and channeling its patients to Dominican.

[28] For a large number of clinical procedures there is empirical evidence that outcomes improve with patient volume. See, e.g., Begg *et al.* [1998] and Selby *et al.* [1996].

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described in the preceding paragraph, Watsonville would either have to (1) reduce its price (assuming that its quality remained unchanged); or (2) match Dominican's quality increase. If Watsonville captured some of the patient flow that otherwise would have patronized Community, then it too might be able to realize volume-related quality increases. But if this occurred, then it is unclear why prices would rise unless the transaction also had adverse competitive effects.[29] In a competitive market, prices are determined by cost, not demand (demand determines the equilibrium quantity, but price will be determined by marginal cost). If the quality of certain services increases at both hospitals (but costs remain unchanged), then there will be a market-wide increase in demand for the service, leading to an increase in the total quantity sold. But if marginal costs are constant, and prices are determined competitively, the price at which this service is sold would not change. If prices increase, it suggests that the transaction has increased market power, even if it simultaneously yielded efficiencies.

It perhaps is conceivable that the merger led to other types of quality increases at both Dominican and Watsonville that are not related to volume, but which manifest themselves in greater resource use per patient. If so, we might observe a post-merger increase in expenses per admission or expenses per day—hence prices—at both hospitals, other things held constant. We carry out two tests of this hypothesis. First, we construct dependent variables equal to the difference in per admission expenses between Dominican (Watsonville) and the peer group, and regress this difference against the same explanatory variables employed in the column (c) regressions. Column (d) of Tables III and IV reports the results of these regressions. The results of this test do not support the hypothesis of higher post-merger quality. In the Dominican equation, the coefficient on merge suggests only a small increase in per-admission expenses; we cannot reject the hypothesis that there was no post-merger increase in per-admission expenses. Similarly, in the Watsonville expense regressions we find only a small ($79) post-merger increase in per-admission expenses; as with Dominican, we cannot reject the hypothesis that the true coefficient on merge equals zero.

We conduct a second test of the efficiency hypothesis by examining data on patient flows. If the transaction improved the quality of hospital care provided in Santa Cruz County, relative to that provided in hospitals outside the county, we would expect to observe (*ceteris paribus*) an increase in the proportion of Santa Cruz County residents who seek hospital care within Santa Cruz county. To test the efficiency hypothesis,

[29] The other possibility is that marginal cost increases with output. This possibility is difficult to reconcile with the efficiency claims actually put forth by the parties; i.e., that the merger allowed the merged entity to enjoy scale-related reductions in unit cost.

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TESTIMONY

Presented to the

Interim Health Committee on Certificate of Need

October 8, 2007 @ 3:00-4:00 p.m.

by

Wes Cleveland, JD, American Medical Association

Chairman Foster, Chairman Michael and ladies and gentlemen of the Interim Health Committee on Certificate of Need (Committee), my name is Wes Cleveland. I am an attorney who works in the American Medical Association's (AMA) Department of State Legislation. For the past four years I have spent much of my time monitoring national legislative and regulatory certificate of need (CON) developments. I appreciate the opportunity to share with you some of the trends that I have seen, and some of the information I have gathered about CON from reviewing the academic literature and recent state legislative CON studies. I also want to give you a brief sense of how your state's CON program compares with other states.' I hope that the information I will share with you will be useful as you think about your state's CON program and its future direction.

A. Landscape of CON programs and trends

Before I discuss the findings of CON studies, I would like to give you a sense of the differing types of CON programs out there and legislative and regulatory trends. Although 36 states have some type of CON program, state programs can vary widely. Some CON programs apply to a broad range of health care facilities and health services. Within these states, there can, however, be a significant difference in the monetary

thresholds that trigger the application of CON requirements, with some thresholds being "dollar zero" and others being set at millions of dollars, both for facilities and major medical equipment acquisition. A number of other states have, however, more narrowly circumscribed statutes. For example, Florida's program only applies to hospitals, long-term care facilities, hospices, and ICF-MRs. Nebraska's, Oklahoma's, and Ohio's CON programs only apply to long-term care facilities. Illinois' program applies only to health care facilities. At the extreme is Wisconsin, which while having a CON program "on the books," has not had an active CON program for the last 12 to 15 years.

In terms of regulatory and legislative trends, very little has occurred in terms of CON expansion. There have been legislative proposals to reintroduce CON programs in repeal states, but these have made very little headway. At the same time, there has also been little in the way of restricting the scope of CON programs.

Concerning your state's CON program, it appears to me that it is one of the most comprehensive state CON programs. For example, only Alaska, New York, and North Carolina regulate more services (28 to West Virginia's 27). In terms of restrictiveness, the American Health Planning Association ranks the West Virginia CON program as the fifth most restricting CON program in the U.S. ***As you will see, restrictiveness correlates with increased health care costs.***

I would now like to share some thoughts with you about the central findings of a wealth of study concerning CON.

A. CON does not control health care costs.

There is a compelling body of peer-reviewed academic research spanning over three decades, and state legislative-commissioned CON studies, demonstrating that CON programs have failed to achieve their purported purpose-- to restrain health care costs. In fact, there is evidence showing that CON programs have actually *increased* health care costs. A few examples will be sufficient to prove this point, and while there is a wealth of academic CON literature showing that CON has not achieved its objectives, I will generally confine my references to recent state legislative CON studies with the hope that they might be the most relevant to you.

The only academic study I will mention today was the result of a major research project. Published in 1998 in the Journal of Health Politics, Policy and Law by Conover and Sloan, this study was entitled "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?" The study examined the purported cost-control claims of CON over a twenty-year period, and focused on whether *CON repeal led to increased health care costs*. The study concluded, "There is no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations." A number of state legislative-commissioned studies have reached similar findings. For example, a February 2007 CON study prepared by the Lewin Group at the request of the Illinois Legislature and entitled "An Evaluation of Illinois' Certificate of Need Program," concluded that "A review of the evidence indicates that CONs rarely reduce health care costs, and on occasion, increase cost in some states." [Page 16]. In November 2006, pursuant to a request from the Georgia Legislature, the Center for the Report of Data Analyses of

Georgia State University submitted a 264-page "Report of Data Analyses to the Georgia Commission on the Efficacy of the CON Program" (the Georgia Legislature created the Commission). This report concluded, "Across all markets, states ranked as having the most rigorous CON regulation have statistically significantly less competition than non-CON states....Lower levels of competition are associated with higher costs." [Page 7]. That report also found that "CON regulation is associated with higher private inpatient costs." [Page 8]. Still another example is the CON study performed by the Missouri Senate Interim Committee on Certificate of Need released in December 2006. This study found that "Certificate of need acts as an artificial barrier to entry stifling competition and innovation in the healthcare market... Not only does this lead to higher healthcare costs but it also limits patient choice." [Page 13]. There are many other peer-reviewed academic studies that I could cite that have concluded that CON has either failed to control, or has actually increased, health care costs, and I will be happy to provide you with references if that would be helpful to you.

B. CON is not an effective quality improvement mechanism.

Although CON programs were not developed to address quality concerns, some have proposed that CON can promote quality. These quality claims have also been closely examined, and the results are, at best, inconclusive. For example, the Georgia legislative study referenced earlier stated, "There is considerable variation on a number of dimensions of quality across markets. However, there is no apparent pattern with respect to Certificate of Need regulation and no statistical correlation." [Page 9]. The Lewin

Group's report for the Illinois Legislature similarly concluded that, concerning the ability of CON laws to increase the quality of care,

> even the strongest supporters of maintaining the program agree that the area where CON can directly influence quality is narrow....CON laws' impact on quality and care is limited.

[Page ii]. An earlier study from 1999 performed by the Washington State Joint Legislative Audit and Review Committee entitled "Effects of Certificate of Need and Its Possible Repeal," likewise stated, "The evidence is weak regarding the ability of CON to improve quality by concentrating volume of specialized services." [Page 3].

C. CON does not improve access to care.

There is little evidence that CON positively affects access to care. For example, in 2003 the Michigan Department of Community Health commissioned two noted CON public policy scholars at Duke University to evaluate Michigan's CON program. That study, entitled "Evaluation of Certificate of Need in Michigan," found that "CON has limited ability to impact the overall cost of health care or to address issues raised by care for the uninsured and underinsured." [Page 132]. The 2007 Illinois legislative study performed an extensive economic analysis that compared the profit margins of safety-net hospitals in CON-states with safety-net hospitals in non-CON states. The study concluded that its collective research and analysis "do not support the argument that CONs provide a protective effect for safety-net hospitals' financial status" [Page 28] The Georgia legislative commission study found that CON's affect on access was no more than "mixed." [Page 72]. Academic literature examining CON's purported affect on access has reached similar conclusions.

D. Conclusion

In summary, 36 states have some form of CON law. Of those states, West Virginia ranks in the top five in terms of restrictiveness, which is contrary to the national trend of not expanding CON programs. Therefore, based on state legislative CON activity that I have been following for several years, I can tell you that West Virginia's recent decision to authorize a more restrictive CON rule is not in the norm.

I applaud the West Virginia Legislature for its willingness to evaluate its CON Laws, as a number of other state legislatures have recently done. Such an evaluation may be particularly appropriate now, since conclusive evidence demonstrates that CON does not control and may add to health care costs, CON is not an effective means of quality improvement, and CON does not promote access to health care. As the Illinois legislative report perhaps stated best "our results are consistent with a body of literature that indicates CON rarely achieves its stated goals." [Page 28]. I hope that you find this information useful as you think about your own state's CON program.

Thank you

Certificate of Need hinders health care innovation

1. **Posted by The Birmingham News October 14, 2007 2:00 AM**

By MICHAEL MORRISEY and MICHAEL CIAMARRA

Entrepreneurs and innovators are developing new ways to deliver health care that are more convenient, higher 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 that stagger the imagination.

Unfortunately, bureaucratic relics of the past often stand in the way of developing a 21st century, intelligent health system.

Alabama's Certificate of Need is an amazing program that requires hospitals, nursing homes and other medical facilities such as ambulatory surgery centers and diagnostic imaging facilities to have the explicit approval of the state before they can operate. When implemented in the 1960s and 1970s, CON was intended to control rising health-care costs that resulted from cost-based reimbursement.

What is amazing is that there is virtually no rigorous empirical evidence that the program has been effective in reducing hospital or health-care costs and some evidence that it increases costs. This was true in the heyday of the program in the 1980s and is still true in more recent evaluations. Yet, CON continues to exist for hospitals in Alabama and 25 other states and effectively limits new hospital construction and even needed renovation.

Consumers don't save money as a result of the CON program. Currently, hospitals and other protected providers argue that CON

keeps new providers from coming in and taking the profitable patients. It certainly does. Another way to say this is that existing providers are collecting prices which are higher than their costs and probably higher than the new entrants would charge. So, by their own admission, we pay higher prices.

CON provides less choice and less innovation.

Entry of new ambulatory surgical providers is no trivial issue. We all have friends or family members who have had an ambulatory procedure performed that only a few years ago would have required a day or more in the hospital. The American Hospital Association reported that in 2004, there were more than 1.7 outpatient surgeries conducted in U.S. hospitals for every one surgery that required an overnight stay. Ambulatory surgery centers represent a competitive alternative to hospitals for these outpatient procedures.

Nationally, recent research suggests that on average, every free-standing ambulatory center per 100,000 population in a metropolitan area is associated with a reduction of 4.3 percent in the number of hospital-based outpatient procedures. The battle in Georgia was over entry of new providers and choices and ultimately over who gets the patients. In states like Georgia, North Carolina and Alabama, the CON agency plays a big role in deciding who gets the patients and what access those patients have to new technology.

CON is not only focused on keeping out new forms of health care delivery, it is also concerned with how, or even if, existing providers can serve their communities. One need look no further than the burgeoning U.S. 280 corridor in Birmingham or the growth in Madison County near Huntsville to appreciate that many people in increasingly congested areas of the state now have longer travel times to get to a hospital.

In both communities, existing hospitals (and new providers) would

almost certainly be willing to build in the growth corridor. Much of what stops them is the CON process. Any proposed action will be opposed by existing hospitals in the community because of the threat to their established patient flow. So, in addition to the usual construction and operating costs, an effort to expand will be tied up with CON hearings, decisions, appeals and more appeals.

Finally, Alabamians needn't be reminded of the embarrassment of a former governor and a former hospital CEO who were convicted in a federal bribery case associated with an appointment to the Alabama CON board.

Regulatory agencies that provide protection from market competition and thereby offer the potential for substantial profits are tempting targets for unscrupulous politicians, bureaucrats and businesses. These temptations can be overcome with sufficient monitoring and careful processes, but it seems foolish to go through all of that for a program that doesn't provide benefits to the citizens of the state.

The CON program never controlled costs and has become a mechanism to limit competition in health care, making all of us worse off. Alabama's CON is a hindrance. Seven years ago, The Birmingham News noted, "It's time Alabama consider whether CON should be tossed into the dump heap." It's past time. It's time now for the Legislature to dismantle CON completely.

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Competition in Healthcare and Certificates of Need

MARK J. BOTTI
Chief, Litigation I Section
U.S. Department of Justice, Antitrust Division

Before A Joint Session of
The Health and Human Services Committee of the State Senate
and
The CON Special Committee of the State House of Representatives
of the General Assembly of the State of Georgia

February 23, 2007

Good afternoon. I want to thank Chairman Thomas and Chairman Cooper for their invitation to the Antitrust Division of the U.S. Department of Justice to appear before you today and to share our views on the impact of Certificate of Need ("CON") laws on healthcare markets.

My name is Mark Botti. I am the Chief of the Litigation I Section of the Antitrust Division. My group has approximately 30 attorneys and additional staff dedicated to enforcement of the antitrust laws and advocacy of the importance of competition in a number of sectors of the nation's economy. In particular, we focus to a substantial degree on

healthcare markets. In doing that work, we confer closely with a large team of Antitrust Division 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 also have dedicated time to the study of healthcare markets.

My remarks today are built on the work of these professionals and the Antitrust Division's decades long focus on healthcare markets. Over those years, we have brought many 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 understand the competitive forces that drive innovation in and contain the costs of healthcare. We consult regularly with federal and state agencies responsible for the delivery of healthcare services and the setting of healthcare policy. Our attorneys and economists study the latest academic and policy works in healthcare on an ongoing basis. We have on many occasions met informally and formally with experts in the field. For example, in the first half of the 1990s, the Federal Trade Commission and the Antitrust Division committed substantial resources to the study of competitive markets, out of which effort we prepared a series of nine antitrust enforcement principles that guide industry behavior today.(1) I worked on those enforcement statements and am directly responsible for their application. More recently, 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.(3) I oversaw the Antitrust Division's work on those hearings and that report and am the designated point of contact at the Division regarding the report.

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 proper performance of healthcare markets. Indeed, by their very nature, CON laws create barriers to entry and expansion and thus are anathema to free markets. They undercut consumer choice, weaken markets' ability

to contain healthcare costs, and stifle innovation. We have examined historical and current arguments for CON laws. They do not provide an economic justification for depriving consumers of the benefits of free markets. To the extent non-economic goals are pursued, the use of CON laws to help pursue them imposes substantial costs. Those goals can be better achieved through other mechanisms. I will explain our reasoning in more detail in just a moment; but first allow me to respectfully suggest to you our bottom line -- we hope you will carefully consider the substantial costs that CON laws impose on consumers as you evaluate whether to reform those laws in your state.

I have not come here today to discuss the details of any particular proposal before you for the reform of Georgia's CON laws. 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. For your convenience, I am leaving with you the written text of these remarks with citations to relevant sources included.

In offering these remarks, please understand that 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 . . . ."[4] Our overall mission is to preserve and promote 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

Let me set the stage for explaining our concerns about the harm from CON laws by talking for a moment about competition in healthcare generally. No doubt there are aspects of the delivery of healthcare services that make healthcare different from other sectors of the economy. The health of any individual is a sensitive and very important matter. But in our concern over the health and well-being of our fellow citizens, we as government officials should not lose sight of a basic truth -- market forces improve the quality and lower the costs of healthcare services. Increased competition in healthcare markets

does not require us to choose between obtaining the benefits of competition or the delivery of high-quality healthcare. Competition drives innovation and ultimately leads to the delivery of better healthcare. Government intervention can undermine the ability of markets to deliver that benefit.

The proposition that competition cannot work in healthcare is simply not true. Similar arguments, made by engineers and later by lawyers, that competition fundamentally does not work in their industries and is harmful to public policy goals, have been soundly rejected and private restraints on competition have long been condemned.(5) 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 shaping the delivery of healthcare in this country. The Antitrust Division and the Federal Trade Commission have worked diligently to make sure that private barriers to that competition do not arise.(6)

During our extensive healthcare hearings in 2003, we obtained substantial evidence 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." Competition results in lower prices and broader access to health care and health insurance, and in particular non-price competition can promote higher quality.(7)

This finding is not surprising. 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.(8) Ambulatory surgery centers offered patients more

"convenient locations, shorter wait time, and lower coinsurance than a hospital department."[9] 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.[10] 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.

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.

For example, we are on the cusp of a potentially significant advance in how competition empowers consumer choice, thus delivering more quality and containing costs. In an August 22, 2006 Executive Order, the President ordered executive agencies to take steps to promote transparency in healthcare quality measures and pricing and to facilitate the development of health information technology.[11] In implementing that directive, the Department of Health and Human Services (HHS), has launched a transparency initiative for value-driven health care that aims to facilitate the delivery of better care at lower costs. Similarly, private health plans have developed products that give consumers greater choice and more information, with an eye toward improving quality while controlling costs. And new companies are entering the market seeking to provide more information and empower consumer choice in healthcare markets.[12] Capturing the promise of these initiatives, HHS has observed that "[c]onsumer choice creates incentives at all levels, and motivates the entire system to provide better care for less money."[13]

B. CON Laws Create Barriers to Beneficial Competition

CON laws are a classic government-erected barrier to entry. As such, they are anathema to competitive markets. Accordingly, in *A Dose of Competition*, the Department of Justice and the Federal Trade

Commission urged the states to rethink their CON laws.[14]

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 origins 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 expenses predominantly on a "cost-plus basis." This is a very important point. The original reason for CON laws was not, as some have argued, that competition inherently does not work in healthcare or that market forces promote over-investment. Instead, CON laws were desired because the reimbursement mechanism, i.e., cost-plus reimbursement, incentivized over-investment. The hope was that CON laws would compensate for that skewed incentive.

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

- CON laws were not adopted around the country 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, since patients were not price-sensitive, providers engaged in a "medical arms race" by unnecessarily expanding their services to offer the perceived highest quality services.[15]

CON laws appear not to have served well even their intended purpose of containing costs. Several studies examined the effectiveness of CONs in controlling costs. The empirical evidence on the economic effects of CON programs demonstrated near-universal agreement

among health economists that CON laws were unsuccessful in containing healthcare costs.(16)

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. 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.(17)

2. Protecting Revenues of Incumbents Does Not Justify CON Laws

I want to address directly one of the most prominent rationales advanced for keeping CON laws, namely, that incumbent hospitals should be protected against additional competition so that they can use their profits to cross-subsidize care for uninsured or under-insured patients.(18) 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.

The cross-subsidization rationale essentially turns these laws on their head. What started as laws intended to control costs have become laws intended to inflate prices. Ironically, proponents of CON laws now would use these barriers to entry to accomplish precisely what economic theory would predict barriers to entry usually accomplish -- stifle competition, protect incumbent market power, frustrate consumer choice, and keep prices and profits high.

Please do not misunderstand my point here. We are not accusing community hospital proponents of CON laws of seeking these barriers to entry for some improper purpose. We fully appreciate the laudatory

goal of trying to make sure that community hospitals have sufficient funding so that they 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 this laudatory purpose has costs. Importantly, to the extent legislatures choose to help cover health care costs for the indigent, 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 them 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.

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. Put another way, the evidence to date indicates that new competition does not undercut community hospitals' ability to fulfill their charitable mission. Last year, 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.[19] 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.

A third reason why CONs may do more harm than good results from the beneficial effect that new competition has on community hospitals. 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.[20] Community hospitals encouraged physicians to perform procedures on the hospital campus by developing centers of excellence and building physician offices on campus.[21] Overall, community hospitals affected by specialty hospital entry maintained profit margins in line with national averages. Rather than undercutting

community hospitals, we have seen that new entry drives them to do a better job. Thus, CON laws harm society in general by depriving it of the increased efficiency that competition would have brought to the health care market.(22)

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 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.(23) 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.(24) 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."(25)

We have found that existing competitors at times 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.(26) 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 Virgina case, two closely competing hospitals decided to use the CON process to allocate healthcare services between themselves.[27] The hospitals agreed 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.

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.[28] 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.

4. CON Laws Lead To Less Competition and Higher Prices

It is not surprising, given that the prevalent justification for CON laws is to protect the exercise of market power by existing hospitals, that studies show that the removal of CON regulation does not consistently lead to a surge in medical expenditures.[29] Indeed, as one would expect, several studies have concluded that the presence of CON regulations may be responsible for increases in healthcare costs.[30] These findings were supported by the recent study by Georgia State University conducted as part of your state's review. That study showed that rigorous CON regulation is associated with less competitive markets and higher prices for private inpatient care.[31]

III. Framework for Evaluation of CON Laws

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 Georgia should

carefully consider whether, and if yes, to what degree, its CON laws continue to serve the citizens of this state. We offer the following framework for your consideration:

First, we suggest that the enactment or continuation of CON laws should have a significant, clearly articulated justification, because they are government intervention in the marketplace that create barriers to entry into healthcare markets. That substantial justification should have a basis in serious and persuasive market studies that demonstrate that the market has failed in some significant way.

Second, any evaluation of a proposed CON law should consider not only the justification for the law but also identify and weigh the harm to consumers that is likely to result from creating the barrier to entry. The consideration of these potential harms should include the ways in which the regulations could distort the market, affect incentives, or diminish competition. A state should enact or maintain a CON law only if it finds that the justification does more good than harm.

Third, in cases where the evidence does show a greater benefit than harm from a CON law, we urge you to consider whether you can address the problem in an alternative fashion that preserves competition, or at least is narrowly tailored to remedy only the demonstrated need and preserve as much competition as is possible. A state should only use CON laws to address some problem if that problem cannot be addressed without government intervention in the form of a barrier to entry. If a state must erect a barrier to entry, select the approach that accomplishes the objective with the least disruptive effect on competition.

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. We are unaware of evidence that those states which have eliminated CON laws have suffered such harm. The studies, cited above, in fact suggest that elimination of CON laws leads to improved markets. Accordingly, we encourage you to consider carefully whether the maintenance of those laws or the enactment of new ones best serves your citizens.

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.

FOOTNOTES

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

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

3. *Improving Health Care: A Dose of Competition* (July 2004) available at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf. ("*A Dose of Competition*").

4. *See* 1996 Statements, pg. 3.

5. *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).

6. *American Medical Association v. U.S.*, 317 U.S. 519, 529 (1943).

7. *A Dose of Competition*, ch. 3 § VIII and Executive Summary at 4.

8. *Id.*, Ch. 3 at 25.

9. Medicare Payment Advisory Commission (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.

10. A Dose of Competition, Ch. 3 at 24.

11. http://www.whitehouse.gov/news/releases/2006/08/20060822-2.html.

12. See http://www.revolutionhealth.com.

13. See http://www.dhhs.gov/transparency.

14. *A Dose of Competition*, Executive Summary at 22.

15. *A Dose of Competition*, Ch. 8 at 1-2.

16. 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").

17. *A Dose of Competition* at 1-6.

18. *Id.*, Ch. 3 at 36-40.

19. *See* MedPAC 2006 Report.

20. 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).

21. 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).

22. For similar reasons, we have not found persuasive other arguments, such as community planning or quality of care as reasons for erecting barriers to entry through CON laws.

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

24. The *Noerr-Pennington* doctrine of antitrust law holds that under the First Amendment, it cannot be a violation of the federal antitrust laws for competitors to lobby the government to change the law in a way that would reduce competition. *See Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961) ("no violation of the [Sherman] Act can be predicated upon mere attempts to influence the passage or enforcement of laws"); *United Mine Workers v. Pennington*, 381 U.S. 657 (1965) ("joint efforts to

influence public officials do not violate the antitrust laws even though intended to eliminate competition").

25. *A Dose of Competition*, Executive Summary at 22.

26. *United States 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).

27. *United States v. Bluefield Regional Medical Center, Inc.*, 2005-2 Trade Cases ¶ 74,916 (S.D. W.Va. 2005).

28. 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).

29. Christopher Connover and Frank Sloan, Evaluation of Certificate of Need in Michigan (2003) (available at http://www.michigan.gov/mdch/0,1607,7-132-2945_5106-83771--,00.html).

30. Daniel Sherman, Federal Trade Commission, "The Effect of State Certificate-Of-Need Laws On Hospital Costs: An Economic Policy Analysis" (1988) (strong CON programs may increase costs); Christopher Connover and Frank Sloan, Evaluation of Certificate of Need in Michigan (2003) (available at http://www.michigan.gov/mdch/ 0,1607,7-132-2945_5106-83771--,00.html) (CON in some instances may have raised costs).

31. The Effect of Certificate of Need Laws on Cost, Quality, and Access (Georgia State University, Oct. 2006); Report of Data Analyses to the Georgia Commission on the Efficacy of the CON Program, at 9 (Nov. 2006).

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About *PH&S*

About Providence Health & Services in Alaska

May 10, 2007

Providence Health & Services (PH&S) is positioned to dominate the state's health care market indefinitely with three times more operating revenue than its closest competitor, $321 million budgeted to build new facilities between 2005 and 2008, and the former Alaska Commissioner of Health and Social Service in charge of strategic development.

PH&S Alaska operates four hospitals and many other ventures in south-central Alaska. The company has no presence outside of south-central Alaska.

According to PH&S's newly released 2006 financial statement, PH&S Alaska produces the highest profit margins of all PH&S regions. In 2006, Providence Alaska created $57 million in total profit for a 9.6% margin. While the Alaska division produces 10% of PH&S operating revenue, it generates 16% of the system's operating profit.

Providence Alaska Medical Center in Anchorage alone accounts for almost half of all hospital admissions in the state. The company employs more than 4,000 people, making it Alaska's largest private employer.

Operations

Anchorage:

Anchorage is the base for PH&S in Alaska. The company operates one of the city's two general acute care hospitals as well as long term care and assisted living facilities, the Providence Physician Service Organization, and an ambulatory surgery facility (Providence Surgery Centers, LLC). The company also recently opened the 60-bed St. Elias Specialty Hospital as a for-profit joint venture with BridgeCare, an Alabama based firm.

Providence Alaska Medical Center (PAMC)
PAMC is the largest hospital in Alaska. The 363-bed facility accounted for 42% of the state's total acute care hospital admissions in 2005—and more than half of all hospital profit in the state. PAMC provides a full range of medical, surgical, and tertiary services at the main hospital, Providence Children's Hospital, Providence Cancer Center, Providence Heart Center, and Providence Maternity Center. Providence LifeGuard Air Ambulance transports patients by helicopter from facilities around the state to PAMC. In 2005 PAMC posted $29.5 million in net profit, or a 6.8% total margin.

PH&S Alaska Hospitals – 2005*		
	PH&S hospitals avg.	Alaska hospitals avg.
Alaska Market Share by admissions	17%	n/a
Operating profit margin	8.7%	5.9%
Total profit margin	9.3%	8.5%
Occupancy Rate**	67%	58%

NOTE: PH&S Alaska figures are only for their acute care hospitals in 2005. Neither complete figures for PHS Alaska in 2006 nor hospital-level information for 2006 are available to date.
*The state of Alaska does not collect or distribute hospital financial or utilization data. Audited financial statements from each of Alaska's thirteen acute care hospitals were used to compute these figures.
** Occupancy rates were calculated using total inpatient days reported in audited financials divided by available bed days as reported in Medicare cost reports.

Mary Conrad Center
This 90-bed nursing home has been managed by Providence since 1986. PH&S Alaska describes the skilled nursing and rehabilitation services facility as a "home-like environment."

Providence Extended Care Center
This 224-bed long-term care facility is the largest in Alaska.

Beyond Anchorage:

Providence operates three municipally owned hospitals outside Anchorage—operating facilities at Seward and Valdez under management agreements and a facility at Kodiak under a lease.

Providence Seward Medical Center (PSMC)
Providence has operated a 6-bed hospital and a 43-bed long term care facility in Seward since 1996. In 2005, PSMC lost $402,000 for a -3.7% total margin.

Providence Valdez Medical Center (PVMC)
The City of Valdez pays PH&S to manage this 11-bed hospital and a 19-bed long term care facility. In 2005, PVMC lost $146,000 for a -1.9% total margin.

Providence Kodiak Island Medical Center (PKIMC)
Providence began managing this 25-bed hospital and a 19-bed long-term care facility in 1998 under a 10-year renewable lease from the Kodiak Island Borough (KIB). PH&S collects no management fee and actually pays the borough $720,000 annually for the right to operate the facility. In 2005, PKIMC posted a $769,000 profit for a 3.6% total margin.

Growth

PH&S is cementing its dominance in Alaska with a plan to spend $321 million to build a host of new facilities by 2008, including:

- new medical office buildings
- a heart institute
- another cancer center
- administrative offices
- visitor housing and
- a 40-acre commercial development that 'surrounds' the competing Mat-Su Regional Medical Center.

Expanding its strength in the long-term care market, PH&S opened the for-profit St. Elias Specialty Hospital in Anchorage on December 18, 2006. This $24 million facility, a partnership between PH&S and Bridgecare Hospitals from Alabama, is the only one of its kind in the state. St. Elias Specialty Hospital focuses on non-critical patients requiring long-term acute care, and will receive patients from hospitals throughout the state. Once St. Elias Specialty Hospital demonstrates that patients stay at the hospital an average of more than 25 days, administrators say that they will seek certification by Medicare as a long-term acute care hospital.

The State of Alaska is currently considering applications for certificates of need for seven PH&S Alaska projects totaling $48 million. The most controversial project seems to be the proposed imaging center in the Matanuska-Susitna (Mat-Su) Valley.

Providence Projects in Certificate of Need Process – May 9, 2007

Project	Status	Value
Anchorage – Cardiovascular Observation Area Expansion	Application Complete	$ 1,312,575
Anchorage - Catheterization Labs	Application Complete	$5,001,614
Anchorage - Outpatient Therapy Services	Application Received	$3,643,386
Anchorage Ambulatory Surgery Center	Hearing Scheduled	$9,600,000
Seward - Providence Wesley Care Center	CON Approved	$26,100,000
Anchorage Abbott Road Imaging Facility	Appealed	
Mat-Su Imaging Services	Appealed	
Total		$47,657,775

Matanuska-Susitna Valley Controversy

After losing a bid to partner with the Valley Hospital Association, PH&S Alaska is aggressively undermining the new community hospital in Mat-Su Valley, first by purchasing land surrounding it, and now by seeking to open a competing imaging center without Certificate of Need approval.

In 2002, the Valley Hospital Association decided to build a new community hospital in the Matanuska-Susitna Valley that could treat more patients locally. Lacking the cash to undertake the project, the association's board entertained several proposals, and ultimately entered into a joint venture with for-profit Triad Hospitals, Inc. Under the agreement, Triad agreed to spend up to $75 million on the new facility, maintain a local presence on the board of directors with 50%

of the board's vote, and proportionately share the hospital's profits with the community. The association rejected a bid from Providence out of concern that the company would push to stabilize patients and then transfer them to Providence Anchorage Medical Center rather than keeping them at "our own full-fledged hospital" said Elizabeth Ripley, spokeswoman for the Mat-Su Valley hospital. "We wanted to deliver care locally," she said.

The community broke ground on the new 74-bed Mat-Su Regional Medical Center on May 17, 2004 and opened its doors on January 27, 2006.

Shortly before the deal with Triad was approved, Providence had announced it had purchased an option to buy 99 acres of land just south of the new Mat-Su hospital. In June 2005, Providence announced that it would relocate two of its physician clinics to a new medical office building it was developing on the land. In December 2005, Providence announced a joint venture with the Imaging Associates of Providence (IAP) radiology group. The joint venture, Mat-Su Imaging Services, would locate in the new office building.

Providence did not file an application for a certificate of need for the imaging facility; but in March 2006 Norman Stephens, CEO of the new Mat-Su hospital, wrote to Health Commissioner Karleen Jackson asking the state to investigate whether or not a certificate of need was required. In doing so, Stephens said, "Mat-Su Regional Medical Center may be adversely and substantially affected by the violation of the Certificate of Need statute..."

Commissioner Jackson agreed with PH&S Alaska that the imaging facility was actually a physician's office, not a "health care facility," and was therefore exempt from the certificate of need requirements. Mat-Su appealed, arguing that "IAP does not meet the exemption for physician offices as its majority investor is a hospital, Providence Health System. Every day that IAP is allowed to continue operating its MRI is a violation of the law and financially penalizes Mat-Su Regional." (Imaging is a widely known as a lucrative health care business that acute care hospitals often resent because independent imaging operations can "cream" revenue away from a hospital's fragile service mix.)

Jackson rejected that appeal. She reversed herself, however, after a court ruled that an independent diagnostic testing facility in Fairbanks, Alaska, required a Certificate of Need. She informed IAP on August 17, 2006 that a certificate of need would be required for Mat-Su Imaging Services.

At the request of Ed Lamb, CEO of Alaska Regional Medical Center, Jackson informed Providence that IAP's Anchorage Abbott Road Imaging Facility would also require a certificate of need.

Providence appealed both decisions. Administrative Law Judge Terry L. Thurbon consolidated the cases in November 2006, and is now considering the matter.

PH&S Alaska currently owns at least 40-acres of land that surrounds the Mat Su Regional Medical Center. The former Providence employee who secured the land purchase while he worked for the hospital now holds a 10-year development agreement that gives him exclusive rights to develop the property, where he hopes to build a hotel, retail and office space, and several "destination restaurants." Asked about the property "in the vicinity of the new Valley Hospital," Providence Alaska Region CEO Parrish stated, "It's not only in the vicinity, it completely surrounds it."

Executives

Al Parrish became CEO of the Providence Alaska Region in 2002 after working in the Alaska tourism industry for the previous 20 years. In a recent interview, Parrish acknowledged PH&S Alaska's ambitious plans, saying, "It probably does give the appearance, which is an accurate appearance, that we really have a lot of irons in the fire. But the need was there and we said we will address that need." Providence reports Parrish's 2005 salary as $417,641.

Robert Dvorak earned a $338,162 salary in 2005 for his work as Providence Alaska's chief financial officer.

Susan Humphrey-Barnett is the area operations administrator for PH&S Alaska, where she is in charge of operations outside of PAMC. Her 2005 salary was $191,844.

Joel Gilbertson, former Alaska Commissioner of Health and Social Services, is now regional

Alaska Health, Education & Social Services Committee

Testimony on Certificate of Need

by

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

January 25, 2008

Testimony Related to Alaska Senate Bill 245: *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 25, 2008

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

Good afternoon Senators and Ms. Chairman. Thank you for the opportunity to speak before members of the Alaska Senate Health Education & Social Services Committee regarding the proposed Senate Bill 245: "*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 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 have been 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, and 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, and 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 experience, it is my informed view that this committee should vote to advance Senate Bill 245 (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 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;**
6. **CON is a Barrier to Healthcare Innovation;**

[1] Health Care Plan/Commission/Facilities by Alaska Senate, Alaska Senate, January 2008, www.legis.state.ak.us/basis/get_complete_bill.asp?session=25&billSB245(2008)

7. **CON Reduces Access and Patient Choice; and,**
8. **CON Hasn't Improved Healthcare Quality.**

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 "*Protectiorist 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. The federal CON legislation that was passed in 1974 had, within over a decade, became apparent that the effort 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 Senate Bill 245 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]

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

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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.

> *"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 needs*".[14]

Following testimony at numerous hearings from industry representatives and legal, economic,

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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).

[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.

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, in a May 24, 2005 "*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*," the agency stated that, " *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 hospital 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,

> "*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*

[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.

> *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 succeed in lowering healthcare costs."*[22]

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[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
[22] "Beyond Health Care Reform: Reconsidering Certificate of Need Laws In a Managed Care Competition System", McGinley, PJ., Florida State University Law Review, 1995.

Thomas Obermeyer

From: Tom Piper [macquest@mac.com]

Sent: Friday, February 15, 2008 8:41 AM

Subject: Missouri CON story

I have attached below the text of a lead editorial in today's St. Louis Post-Dispatch newspaper.

Tom

Pros and CON

02/15/2008

Long before the movie "Field of Dreams" and its iconic theme of "if you build it they will come," Dr. Milton I. Roemer reached the same conclusion. But instead of baseball fields, he was thinking about hospital beds.

Dr. Roemer's simple observation: The more that hospitals expand and the more hospital beds that are made available, the more beds that will be filled with patients and the more money that will be spent on health care. In other words, supply — not price or need — drives much of the demand for health care.

The idea stands traditional market economics on its head. Yet it's so widely accepted by health care economists that it's known today as Roemer's law.

It explains why many states require hospitals that want to build expensive new facilities to get an approval called a Certificate of Need, or CON. Missouri is one of those states. But a group of legislators with a shaky grasp of health care economics wants to change that.

House Bill 1806 would eliminate the CON process for hospitals and free-standing surgical centers. It was voted out of committee last week.

HB 1806 is being pitched as a way to increase competition and decrease costs, but it would have the exact opposite effect. That's counter-intuitive, especially to people who aren't professionals in health care economics. But it's been demonstrated time and again, and not just for hospital beds.

Wisconsin and Ohio both did away with their CON requirements. But the promised savings failed to materialize. What came instead is exactly what Dr. Roemer would have predicted.

— 26 new hospitals were built when Ohio's CON law was repealed.

— 82 new multi-million dollar MRI and CT scan centers were opened.

— The number of open heart surgeries performed in the state jumped by 38 percent. Many were judgment calls, done at the discretion of doctors who otherwise would opt for a more conservative approach than surgery.

When Pennsylvania's CON law was repealed, the number of MRI machines jumped from 78 to 187, and capacity at cardiac catheterization labs jumped by 90 percent.

All that new equipment and expertise has to be paid for somehow. A 2001 study by Chrysler, Ford and General Motors shows the effect. The study examined health costs over several years in eight states, including Missouri. It found that costs were 11 to 39 percent lower in states with CON requirements than in those without it.

In a landmark study, Dartmouth University researchers found that Medicare pays twice as much per patient in Miami as it does in Minneapolis. The difference largely is because Florida patients are more likely to be referred to medical specialists, where they often are given expensive tests and admitted to hospitals.

But the patients in Miami don't live longer or have a better quality of life than those in Minneapolis. A more recent Dartmouth study found that patients in cities where health spending was highest actually died sooner than those where it was lower.

National health spending grew by 55 percent between 2000 and 2006, from $1.3 trillion to $2.1 trillion. That trickles down in the form of higher spending on Medicaid and bigger premiums for state employees' insurance. It's understandable that Missouri lawmakers would be looking for a way to slow that staggering rate of growth.

But repealing CON requirements on hospitals and surgical centers would be like trying to douse a fire with gasoline. The St. Louis Area Business Health Coalition, made up of big companies that provide insurance to their workers, testified against HB 1806 last week. The coalition analyzes health costs and hospital performance in the region. It often publishes information that hospitals would prefer go unnoticed.

Lawmakers on the House Special Committee on Healthcare Transformation, which approved the CON repeal, obviously didn't hear what the professionals had to say. Legislative leaders should sidetrack this ill-considered bill or we'll all end up paying higher prices.
spacer

Senate Bill - 245

Date: 2-25-2007

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's 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 as imposed on the health care in Alaska.

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Kyle R. Fulford
Signature: Kyle R. Fulford
Address: P.O. Box 3071 // Anderson AK
Telephone: 1-907-582-2941

Senate Bill - 245

Date: _____

Senator Bettye Davis
Fax: 907-465-3756

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: David B Henry
Signature: [signature]
Address: P.O. Box 60527 Fairbanks, AK 99
Telephone: 907 455 4673

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

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

February 13, 2008

Honorable Bettye Davis, Chair
Senate HES Committee
State Capitol, Room 30
Juneau, AK 99801-1182

Dear Senator Davis:

Referring to **Senate Bill 245, Version K**, the department responses to questions received concerning the definition of health care facility, which includes on p.3, lines 6-8, Sec. 2, (8)(A)(ii), "a facility that is in a community in which a hospital is designated by the department as a critical access hospital," are provided below:

1) ***clarification and a list of which health care facilities in Alaska are designated by the department as "critical access hospitals;"***

Critical Access Hospitals in Alaska: (Medicare certified)

Cordova Community Medical Center
Kanakanak General (Dillingham)
Ketchikan General
Maniilaq Health Center (Kotzebue)
Norton Sound Regional Hospital (Nome)
Petersburg Medical Center
Providence Kodiak Island Medical Center
Providence Seward Medical & Care Center
Providence Valdez Medical Center
Samuel Simmonds Memorial (Barrow)
Sitka Community
South Peninsula (Homer) *
Wrangell Medical Center

*Applying to be designated as a CAH

Critical Access Hospitals are small, rural hospitals that are financially challenged given the limited population size they serve. These are hospitals that are located in a county (borough) considered rural, is located more than a 35 mile drive from another facility or is a necessary provider of health care services to residents in the area, and has no more than 25 in patient beds.

2) ***how long they are designated as "critical access hospitals;" – because CON protection expires with repeal per page 12, Sec. 13, July 1, 2010;***

Designation as a "critical access hospital" is ongoing, unless the hospital requests another type of designation as a hospital from CMS (Centers for Medicare and Medicaid Services), or they no longer meet the criteria for designation as a "critical access hospital", such as having over 25 beds.

3) ***whether the definition of "critical access hospital" on page 3, lines 21-24, Sec. 3, (11) is what the state uses under federal definitions – because Jean Mischel, in a cursory look at over 100 pages of federal statutes and regulations cited in the bill, found that the section seemed only to apply to rural areas; yet, she noted, for many purposes, all of Alaska is considered "rural" under federal law;***

That definition is correct.

The definition in federal regulation for Medicare indicates that "rural areas" refer to places outside of Metropolitan Statistical Areas and "large urban areas" which are defined as having more than 1,000,000 people. Thus all of our designated "critical access hospitals" are in rural areas.

4) ***Based on state designation of "critical access hospitals," are Providence, Fairbanks Memorial, and Bartlett hospitals considered "critical access hospitals?***

Providence, Fairbanks and Bartlett hospitals are not "critical access hospitals" as noted in the first question and response above. Each of these hospitals has over 25 beds and therefore do not meet the criteria for being designated as "critical access hospitals." In addition, Providence hospital is located within 35 miles of another hospital which would also disqualify them for designation. However, Providence has facilities in locations outside of Anchorage that are "critical access hospitals."

Sincerely,

Sherry Hill
Assistant Commissioner for Public Affairs

cc: Senator John Cowdery, Capitol Building, Room 101
Senator Kim Elton, Capitol Building, Room 506
Senator Joe Thomas, Capitol Building, Room 510
Senator Fred Dyson, Capitol Building, Room 121
Karleen Jackson, Commissioner
Jay Butler, Chief Medical Officer
Wilda Laughlin, Special Assistant
Russell Kelly, Governor's Office, Legislative Director
Mindy Rowland, Governor's Office, Deputy Legislative Director
Anna Kim, Special Assistant
Stacie Kralie, Chief Assistant Attorney General
Deborah Behr, Chief Assistant Attorney General

Don Burrell

From: Deborah Sward [deborah.sward@ncsl.org]
Sent: Tuesday, February 12, 2008 8:54 AM
To: Don Burrell
Subject: NCSL Emerging Health Leaders Conference Call for Legislative Staff

Dear Mr. Burrell:

You have been selected as a knowledgeable legislative staffer with previous interaction with NCSL's Emerging Health Leaders Project (also known as CHAP or Critical Health Areas Project). As we begin the third year of the CHAP project, we are seeking your help. We would like your ideas on how to involve legislative staff in this project in a more central way.

Over the past two years, CHAP has provided training, research support and technical assistance to legislators who are likely to be future state health policy leaders and have been appointed by their state's legislative leadership. CHAP focuses on four health issues: chronic care and quality, healthcare access, addiction prevention and treatment, and the health care workforce. Currently, staff designated by CHAP legislators receive listserv notices and publications and, at times, attend meetings with or instead of their states' CHAP members. As we plan CHAP activities for the year, we would like to consider new strategies to better meet the needs of legislative staff working on state health policy.

We invite you to participate in a conference call to share your thoughts on strengthening the project's involvement with legislative staff. Please let us know whether you can participate and indicate which of the three times listed below (or others) works best for you for a phone conversation. Please return the form at the bottom of this page by fax or email to Deborah Sward at (202)737-1069 or deborah.sward@ncsl.org. Prior to the call, we will send you discussion questions and dial-in instructions.

Thank you for considering this request. We look forward to talking with you. For more information on CHAP, please contact Tara Lubin at (202)624-3558 or at tara.lubin@ncsl.org.

Regards,

Deborah Sward
On behalf of
Donna Folkemer, Group Director
Forum for State Health Policy Leadership, National Conference of State Legislatures RSVP Information - CHAP Staff Conference Call Please fax or email to Deborah Sward at (202)737-1069 or deborah.sward@ncsl.org

Name Don Burrell Jr
State Alaska Title H.E.S.S. Committee Aide
Email Address don.burrell@legis.state.ak.us Phone # 907-465-4906/907-269-0114

X I would like to participate in the CHAP staff conference call.
Availability (please check all that apply):
___Friday, February 29, 2008; 3:00-4:00 p.m. ___ Other: _____
___Monday, March 3, 2008; 3:00-4:00 p.m.
X Tuesday, March 4, 2008; 3:00-4:00 p.m.
___ Wednesday, March 5, 2008; 3:00-4:00 p.m.
___I will not be participating.

Please list any previous or current involvement with CHAP if applicable (e.g. receiving CHAP newsletter): CHAP Meeting October 3-5, 2007 - St. Louis, Mo

Alaska State
Legislature
State Capitol
Juneau, AK 99801
907 465-3822 office
907 465-3756 fax
From the Office of Senator Bettye Davis

To: Legal Services **Fax:** 465-2029; phone: 465-2450

From: Thomas S. Obermeyer **Date:** 2/19/2008

Re: Request for typed amendments drafted to revise CSSB 245( ), Work Draft 25-GS2050\L (dated 2/11/08) -see attached **Pages:** __12__ pages including cover

CC:

X **Urgent** **For Review** ☐ **Please Comment** **Please Reply** ☐ **Please Recycle**

Please rush typed amendments, if possible, before HESS meeting Wednesday, 2/20/08 at 1:30 p.m.

To Whom It May Concern:

Senator Davis asks if you could type and fax or hand-deliver amendments for the changes marked up on the attached copy of work draft 25-GS2050 L by the time of the meeting Wednesday, February 20, 2008 at 1:30 p.m. Senator Davis prefers to discuss these changes with the HESS Committee in a form easier to read if possible. She does not want a CS at this time.

Please call me in the morning if you are unable to draft amendments by time of hearing.

Thank you for your consideration.

Tom Obermeyer
465-3762

TRANSACTION REPORT

FEB-19-2008 TUE 06:40 PM

FOR: Senator Bettye Davis 9074653756

SEND

DATE	START	RECEIVER	TX TIME	PAGES	TYPE	NOTE	M#	DP
FEB-19	06:39 PM	94652029	1'28"	12	FAX TX	OK	975	

TOTAL : 1M 28S PAGES: 12

Alaska State Legislature
State Capitol
Juneau, AK 99801
907 465-3822 office
907 465-3758 fax
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Please call me in the morning if you are unable to draft amendments by time of hearing.

Thank you for your consideration.

Tom Obermeyer
465-3792

2s GS2056\I
Mischel
2/11/08

CS FOR SENATE BILL NO. 245( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; amending the certificate of need requirements to exclude expenditures for diagnostic imaging equipment in certain circumstances; and providing for an effective date."

Suggested title changes coming

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to

develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

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

(a) Except as provided in **(e), (d), and (f)** [(c) AND (d)] of this section, a person may not make an expenditure of $1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the department:

(1) construction of a health care facility;

(2) alteration of the bed capacity of a health care facility; or

(3) addition of a category of health services provided by a health care facility.

*** Sec. 3.** AS 18.07.031(e) is amended to read:

(e) In

(1) (a) of this section, "expenditure" includes the purchase of property occupied by or the equipment required for the health care facility and the net present value of a lease for space occupied by or the equipment required for the health care facility; "expenditure" does not include costs associated with routine maintenance and replacement of equipment at an existing health care facility;

(2) (f) of this section, "critical access hospital" refers to a facility designated as a critical access hospital by the department by regulatory authority exercised under AS 18.05 or AS 18.20.

*** Sec. 4.** AS 18.07.031 is amended by adding a new subsection to read:

(f) Notwithstanding the limitations in (a) of this section, a person may make an expenditure of $1,000,000 or more for diagnostic imaging equipment without authorization under the terms of a certificate of need issued by the department if the equipment is used in a health care facility that

(1) is located in a

(A) borough with a population of 60,000 or more; and

(B) a city that does not have a facility designated by the department as a critical access hospital; and

(2) has at least a 50 percent ownership by one or more physicians licensed in the state who are qualified to interpret, and actually interpret, diagnostic images produced by the equipment in the facility.

*** Sec. 5.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care Planning and Information.

Article 1. Alaska Health Care Commission; State Health Plan.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purposes of the commission are

(1) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state; and

(2)

(3) to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Sec. 18.09.020. Composition; chair. (a) The commission consists of 13 members as follows:

~~(1) the state officer assigned the duties of medical director for the department;~~

(1) one member representing the ~~Department of Administration~~ Governor, appointed by the ~~commissioner of administration~~ Governor;

~~(3) one member representing the Department of Commerce, Community, and Economic Development, appointed by the commissioner of commerce, community, and economic development;~~

~~(4) one member representing the Department of Labor and Workforce Development, appointed by the commissioner of labor and workforce development;~~

(2) ~~six~~ three public members, appointed by the governor; one of the members appointed under this paragraph must be a small business owner in the state;

(3) three health care providers representing

(4) ~~one~~ two member from the house of representatives, appointed by the speaker of the house;

(5) ~~one~~ two member from the senate, appointed by the president of the senate; and

(6) one member representing Alaska Rural Health care system.

~~(8) one member representing the Office of the Governor.~~

(7) one member representing health care insurance

(b) The department's representative appointed under (a)(1) of this section shall serve as chair of the commission. Governor's

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(a)(5) serve for staggered terms of ~~three~~ Five years.

1> hospitals, physicians and mental health

To review and approve the department's plan (2) which shall require data, which data will be required, with health facility types will to report, required to begin reporting, and the reporting system to be imposed

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) The governor may remove a public member of the commission from office only for cause.

Sec. 18.09.040. Executive director. The commission shall employ an executive director with appropriate health care policy experience, who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing proceedings and other activities, including provisions concerning a quorum to transact commission business and other aspects of procedure; frequency and location of meetings; and establishment, functions, and membership of committees.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for

(A) encouraging personal responsibility in prevention and healthy living for all residents of the state;

(B) reducing health care costs for all residents of the state to ~~below the national average~~; rate of growth in make it more affordable.

(C) ~~ensuring~~ improving access in communities to safe water and wastewater systems;

(D) developing a sustainable health care workforce in the state;

(E) ~~ensuring~~ improving access to quality health care for all residents of the

state; and

(4) increasing the number of residents of the state who are covered by insurance for health care services.

(b) The commission shall review and approve health care information for placement on the department's database developed under AS 18.09.110 and establish a schedule for implementation of the database and reporting requirements under AS 18.09.120.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities.

Sec. 18.09.080. Compensation, per diem, and expenses. A public member appointed to the commission under AS 18.09.020(a)(5) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

Article 2. Alaska Health Care Information Office.

Sec. 18.09.100. Office. The Alaska health care information office is established in the department. The purpose of the office is to improve access by residents of the state to consistently updated

(1) information about health care ~~facilities~~ services price & quality to aid consumers ~~of health care services of health care facilities in the state; and~~ in making health care decisions;

(2) information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110. Dissemination of information. (a) The department shall establish and maintain an information database on the Internet of information about [all] delete health care facilities in the state to provide objective, unbiased, and factually based information on health care [facilities] services in the state. The department may require those health care facilities to provide information in a standard form or format to the department for placement in the database. Before information is placed on the database, the commission shall review the information for accuracy with the health care facility.

(b) The database developed under (a) of this section ~~shall~~ may include the following

do you want to make this change?

(1) a list of preferred drugs approved by the department for reimbursement by the department;

(2) a complete list, organized by region and address, of

(A) health care facilities located in the state;

(B) licensed pharmacists and pharmacies located in the state;

(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state;

(G) public assistance offices of the department;

Do you want to make these changes.

[(3) a list of the 100 most commonly prescribed medications in the state and the source and price, updated monthly, of the medications; 7 -- ? means what ?

(3) a list of the 100 most commonly conducted medical procedures in the state, organized by the cash and negotiated price of the procedure at available providers and insurers, updated annually; the list must include medical procedures covered by workers' compensation under AS 23.30;

very difficult to define or do.

(4) available hospital ratings, including the rates of hospital acquired infections and mortality occurring at each hospital located in the state;

such as Hospital Compare

(5) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, that includes the location of available sites that provide care and treatment related to those issues;

(6) a list of procedures approved by state agencies for emergency response and treatment;

What is this.

(7) disease management support information;

(8) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

(B) links to Internet websites for purchasing insurance policies;

(C) an explanation of mandatory and optional insurance coverage;

(9) a list of primary care clinics that cater to uninsured and self-pay patients; and

(10) a list of physicians that accept new Medicare clients

(11) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility.

(c) The department may contract with a private entity to provide services and information required under (a) of this section.

(d) The department shall develop and consistently update an Internet website to provide residents of the state timely and accurate information regarding prevention and healthy living.

(e) The department shall post and make available information related to the commission, including the commission's annual reports under AS 18.09.070(c).

Sec. 18.09.120. Mandatory reporting. (a) A health care facility shall provide to the department, based on a schedule set by the commission under AS 18.09.070(b), the following information related to the facility's health care services for placement in the database developed under AS 18.09.110:

(1) information on costs to the consumer for health care services; which includes both facility and physician components of care

(2) types of insurance and payment accepted by the health care facility for health care services;

(3) each location where the health care facility operates, and the hours of operation;

(4) the types and scope of health care services offered at the health care facility;

(5) the Internet address of any Internet website of the health care facility the purpose of which is to provide factual information to aid the consumer;

(6) any other readily accessible information that the department determines would help the consumer to make informed decisions about the health care

facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of a failure to report under (a) of this section and give the health care facility an opportunity to contest or cure the failure. If the health care facility does not promptly cure the failure, the department shall post the notice of failure on the database developed under AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide to the commission for placement on the database developed under AS 18.09.110 information regarding an adverse action taken against a health care facility in the state or against a licensed professional practicing in a health care facility in the state; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "costs to the consumer" means actual price paid by the consumer for health care services;

(3) "department" means the Department of Health and Social Services;

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing

services in the state;

(C) a provider of a home and community based waiver service that is certified under regulations adopted by the department;

(D) a provider of personal care services that is certified under regulations adopted by the department.

*** Sec. 6.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

*** Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. Sections 2 - 4 of this Act apply to health care facilities in existence or proposed on or after the effective date of this Act. A decision of the Department of Health and Social Services made before the effective date of this Act denying or granting a certificate of need that was applied for or issued for a health care facility described in AS 18.07.031(f).

word being executed by Rep Kelly's office

added by sec. 4 of this Act, shall be void and unnecessary. A pending application for a certificate of need for a health care facility described in AS 18.07.031(f), added by sec. 4 of this Act, shall be returned to the applicant.

*** Sec. 8.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 9.** Section 8 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 10.** Except as provided in sec. 9 of this Act, this Act takes effect July 1, 2008.

~~* Sec. 11.~~

Notes:

1) need sunset date after five years for Commission.

2) Mandatory reporting on page 8, beginning with line 17 should have effective date of, July 1, 2009 to allow Commission time to define reporting requirements for each health facility type, and to allow the department to adopt regulations

3) Need authority for department to require reporting by pharmacists and physicians. How do I add this?

4) Section 4 of this Act takes effect immediately.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

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

February 28, 2008

Honorable Bettye Davis, Chair
Senate HES Committee
State Capitol, Room 30
Juneau, AK 99801-1182

Senator Davis:

Referring to **Senate Bill 245, Version L and Amendments dated 2/20/08**, the department provides the following responses to questions received during the hearing of February 20, 2008.

RE: composition of the Health Care Commission

DHSS comment on the Amendment to change the membership of the Commission to:

2 members representing the Governor and appointed by the Governor
3 public members
3 health care providers representing hospitals, physicians, and mental health
2 members from the House of Representatives
2 members from the Senate
1 member AK Tribal Health Care System
1 member representing Health Care Insurance

Page 4, line 12, delete (1): The Department feels that the department needs to be represented on the Commission, and the Chief Medical Officer should be that person OR a DHSS representative to be designated by the Commissioner of Health and Social Services. An amendment is attached which proposes the following composition of the Commission,

with 9 voting members, one of which will serve as chair appointed by the Governor:

2 state agency representatives, of state agencies providing, paying for or monitoring health care services or addressing employment issues in the state (appointed by the Governor)
1 member from the House of Representatives appointed by the speaker of the house
1 member from the Senate appointed by the president of the senate
5 public members (appointed by the Governor):

- 1 hospital representative
- 1 licensed physician
- 1 health care consumer
- 1 small business owner in AK

And 4 non-voting members:

1 DHSS commissioner or commissioner's designee
1 Mental Health Trust Authority representative (appointed by the Governor)
1 Alaska State Medical Association member (appointed by the Governor)

Questions on information collected by the Information office and disseminated on the state Web Site:

Page 7, line 14 (Amendment): eliminates collection of information regarding prescription drug costs.

The Department objects to this change. Consumers should be able to compare Prescription drug costs of the most common prescription drugs.

Page 6, line 30 (Amendment) Replaces "must" with "may"

The Department prefers retaining "must," as it needs to be clear that the information and data collected from health care providers is all posted on the web site.

Questions regarding Certificate of Need:

Does the Department/Administration have a comment on Sections 2, 3 and 4 of the SB245, version L, which changes Governor's proposal regarding the Certificate of Need program?

Governor Palin continues to support repeal of the Certificate of Need program, with some exceptions. The exceptions to a complete repeal of CON that are acceptable to Governor Palin includes a two year delayed repeal of Certificate of Need for Nursing Homes, Residential Psychiatric Treatment Centers, and Communities with Critical Access Hospitals.

An amendment to SB245, Version, which accomplishes this intent, is attached.

In addition, the Department respectfully requests consideration of the **following amendments** to SB245, Version L, attached.

- Page 7, Sec. 18.09.110 paragraph (4) (Page 7, lines 16-19): modify information collected from health care providers
- Sec. 18.09.990 (page 9): need to add a definition of pharmacies and other providers.

Also, to ensure that the appropriate facility definitions are included in this legislation, **the attached amendment defines** the various health care facilities, and it also exempts Tribal Health entities owned or operated by the federal government, Indian Tribe or tribal organization from any Certificate of Need requirements.

Version L of SB245, Sections 2-4, resolves some, but NOT all, of the pending litigation. To eliminate all pending litigation, the following would need to be changed in HB345:

- include Ambulatory Surgery Centers to be exempt for CON in communities larger than populations of 60,000
- define Physician offices in statute

Sincerely,

Sherry Hill
Assistant Commissioner for Public Affairs

cc: Senator John Cowdery, Capitol Building, Room 101
Senator Kim Elton, Capitol Building, Room 506
Senator Joe Thomas, Capitol Building, Room 510

Senator Fred Dyson, Capitol Building, Room 121
Karleen Jackson, Commissioner
Jay Butler, Chief Medical Officer
Wilda Laughlin, Special Assistant
Russell Kelly, Governor's Office, Legislative Director
Mindy Rowland, Governor's Office, Deputy Legislative Director
Anna Kim, Special Assistant
Stacie Kralie, Chief Assistant Attorney General
Deborah Behr, Chief Assistant Attorney General

25G-2
2/28/2008
(8:22 am)

AMENDMENT

OFFERED IN THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE BY _____

TO: CSSB 245 (25-GS2050\L)

Page 1, line 4, following "**circumstances;**":

Insert "**repealing the certificate of need program for certain health care facilities and relating to the repeal;**"

Page 3, line 1 - 7:

Delete all material and insert:

"(a) Except as provided in **(c), (d), and (f)** [(c) AND (d)] of this section, a person may not make an expenditure of $1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the department:

(1) **except as provided in (4) and (5) of this subsection,** construction of a health care facility **in a community with a critical access hospital;**

(2) **except as provided in (4) and (5) of this subsection,** alteration of the bed capacity of a health care facility **in a community with a critical access hospital;** [OR]

(3) **except as provided in (4) and (5) of this subsection,** addition of a category of health services provided by a health care facility **in a community with a critical access hospital;**

(4) construction of, alteration of the bed capacity of, or addition of a category of health services provided by a nursing home; or

(5) construction of, alteration of the bed capacity of, or addition of a category of health services provided by a residential psychiatric treatment center."

Page 3, lines 8 - 17:

Delete all material.

Renumber the following bill sections accordingly.

Page 3, following line 29:

Insert new bill sections to read:

"* **Sec. 4.** AS 18.07.111(8) is repealed and reenacted to read:

(8) "health care facility"

(A) means, if located or providing services in this state,

(i) an acute care hospital;

(ii) an ambulatory surgical center;

(iii) a critical access hospital;

(iv) an independent diagnostic testing facility;

(v) an intermediate care facility;

(vi) a kidney dialysis center;

(vii) a nursing home;

(viii) a psychiatric hospital;

(ix) a residential psychiatric treatment center;

(B) includes a facility owned or operated by a private person, the state, or a local government of the state;

(C) excludes a facility that is

(i) exempt from state licensure or certification under applicable law and owned or operated by the United States, an Indian tribe, or a tribal organization;

(ii) an office of private physicians or dentists whether in individual or group practice;

* **Sec. 5.** AS 18.07.111 is amended by adding new paragraphs to read:

(11) "acute care hospital" has the meaning given to "hospital" in AS 47.32.900;

(12) "ambulatory surgical center" has the meaning given in AS 47.32.900;

(13) "critical access hospital" means a facility that is a hospital licensed in the state that satisfies the criteria set out in 42 U.S.C. 1395i-4(c)(2)(B) and meets the conditions of participation set out in 42 C.F.R. 485.601 - 485.647;

(14) "independent diagnostic testing facility"

(A) means a fixed-location or mobile outpatient facility that is designed and equipped solely to perform diagnostic testing using major diagnostic testing equipment for an independent diagnostic purpose; in this subparagraph, "independent diagnostic purpose" means to perform a diagnostic test for a patient who has been referred by a physician or medical professional who

(i) is not associated with the facility;

(ii) is treating the patient's specific medical problem; and

(iii) uses the diagnostic test result in the treatment of the patient's specific medical problem;

(B) does not include a practice 100 percent owned by one or more radiologists or physicians whose primary practice is diagnostic imaging and occasionally evaluation;

(15) "intermediate care facility" means a nursing home that is not a skilled nursing facility;

(16) "kidney dialysis center" means a treatment center, including a free-standing hemodialysis unit, that is devoted to the treatment of kidney disease;

(17) "nursing home" means a nursing facility as defined in 42 U.S.C 1396r(a);

(18) "office of private physicians or dentists" means an office that

(A) is 100 percent owned by physicians licensed under AS 08.64 or dentists licensed under AS 08.36; and

(B) provides medical services, whether in individual or group practice, to patients on an ongoing basis;

(19) "psychiatric hospital" means a hospital or part of a hospital that is primarily for the diagnosis and treatment of mental, emotional, or behavioral disorders."

Renumber the following bill sections accordingly.

Page 4, lines 10 - 29:

Delete all material and insert:

"**Sec. 18.09.020. Composition; chair.** (a) The commission consists of nine voting members as follows:

(1) two members, appointed by the governor, representing state agencies providing, paying for, or monitoring health care services or addressing employment issues in health care in this state;

(2) one member from the house of representatives, appointed by the speaker of the house;

(3) one member from the senate, appointed by the president of the senate; and

(4) five public members, appointed by the governor; the appointments made under this paragraph must include the following:

(A) a representative of a hospital in this state;

(B) a physician licensed under AS 08.64;

(C) a consumer of health care services;

(D) a small business owner in the state.

(b) In addition to the members of the commission specified under (a) of this section, the following persons shall serve as non-voting members of the commission:

(1) the commissioner of health and social services or the commissioner's designee;

(2) a member, appointed by the governor, of the Alaska Mental Health Trust Authority established under AS 37.14.001 - 37.14.099;

(3) a representative, appointed by the governor, of the health care insurance industry;

(4) a representative, appointed by the governor, of the Alaska State Medical Association.

(c) The governor shall appoint the chair of the commission from the public voting members appointed under (a)(4) of this section."

Page 4, line 31:

Delete "AS 18.09.020(a)(5)"

Insert "AS 18.09.020(a)(4)"

Page 6, line 12:

Delete "AS 18.09.020(a)(5)"

Insert "AS 18.09.020(a)(4)"

Page 6, line 30 through page 8, line 9:

Delete all material and insert:

"(b) The database developed under (a) of this section must include the following:

(1) a list of preferred drugs approved by the department for reimbursement by the department;

(2) a complete list, organized by region and address, of

(A) health care facilities located in the state;

(B) licensed pharmacists and pharmacies located in the state;

(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state; and

(G) public assistance offices of the department;

(3) a list, updated monthly, of not more than 25 most commonly prescribed medications in the state and the source and price of the medications;

(4) a list, updated monthly, of not more than 25 most commonly conducted medical procedures in the state, organized by the cash and negotiated price of the procedure at available providers and insurers; the list must include medical procedures covered by workers' compensation under AS 23.30;

(5) available hospital ratings, including the rates of hospital-acquired infections and mortality occurring at each hospital located in the state;

(6) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, that includes the location of available sites that provide care and treatment related to those issues;

(7) a list of procedures approved by state agencies for emergency response and treatment;

(8) disease management support information;

(9) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

(B) links to Internet websites for purchasing insurance policies; and

(C) an explanation of mandatory and optional insurance coverage;

(10) a list of primary care clinics that cater to uninsured and self-pay patients;

(11) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility."

Page 9, line 29 through page 10, line 5:

Delete all material and insert:

"(4) "health care facility"

(A) has the meaning given in AS 18.07.111; and

(B) also includes

(i) an assisted living home;

(ii) a free-standing birth center;

(iii) a home health agency;

(iv) a hospice or agency providing hospice services or

operating hospice programs;

(v) an intermediate care facility for the mentally retarded;

(vi) a pharmacy;

(vii) a provider of a home and community-based waiver service that is certified under regulations adopted by the department;

(viii) a provider of personal care services that is certified under regulations adopted by the department;

(ix) a rural health clinic; and

(x) an urgent care facility."

Page 10, following line 5:

Insert new bill sections to read:

"* **Sec. 7.** AS 18.26.220 is amended to read:

Sec. 18.26.220. Facility compliance with health and safety laws and licensing requirements. A medical facility constructed, acquired, improved, financed, or otherwise under the provisions of this chapter and all actions of the authority are subject to [AS 18.07,] AS 47.32[,] and any other present or future state licensing requirements for the facilities or services provided under this chapter. [A MEDICAL FACILITY ISSUED A CERTIFICATE OF NEED UNDER SEC. 4, CH. 275, SLA 1976, BY VIRTUE OF BEING IN EXISTENCE OR UNDER CONSTRUCTION BEFORE JULY 1, 1976, MUST FULLY MEET THE REQUIREMENTS OF AS 18.07 IN ORDER TO BE ELIGIBLE FOR FUNDING UNDER THIS CHAPTER.]

* **Sec. 8.** AS 21.86.030(c) is amended to read:

(c) Nothing in this section relieves a health maintenance organization that wishes to exercise the power described in (a)(1) of this section from the requirements of

(1) [AS 18.07, REGARDING OBTAINING A CERTIFICATE OF NEED;

(2)] AS 47.32, regarding regulation of hospitals; and

(2) [(3)] other statutes applicable to hospitals or other health care facilities."

Renumber the following bill sections accordingly.

Page 10, following line 25:

Insert a new bill section to read:

"* **Sec. 10.** AS 18.07.021, 18.07.031, 18.07.035, 18.07.041, 18.07.043, 18.07.045, 18.07.051, 18.07.061, 18.07.071, 18.07.081, 18.07.091, 18.07.101, 18.07.111; and AS 47.80.140(b) are repealed."

Renumber the following bill sections accordingly.

Page 10, line 28:

Delete "Sections 2 - 4"

Insert " Sections 2 - 5"

Page 10, line 1:

Delete "sec. 4"

Insert "sec. 3"

Page 10, line 2:

Delete "sec. 4"

Insert "sec. 3"

Page 11, following line 3:

Insert new bill sections to read:

"* **Sec. 12.** The uncodified law of the state of Alaska is amended by adding new sections to read:

TRANSITION: PENDING APPLICATIONS, ADMINISTRATIVE APPEALS, AND COURT ACTIONS FOR THE CERTIFICATE OF NEED PROGRAM. The commissioner of health and social services through the Department of Law shall immediately take steps to seek dismissal of pending administrative appeals and court actions concerning the issuance of certificates of need, as appropriate, under AS 18.07, as amended by secs. 2 - 5 of this Act or

implementation of AS 18.07.

*** Sec. 13.** The uncodified law of the State of Alaska, enacted in sec. 12 of this Act, is amended to read:

TRANSITION: PENDING APPLICATIONS, ADMINISTRATIVE APPEALS, AND COURT ACTIONS FOR THE CERTIFICATE OF NEED PROGRAM. The commissioner of health and social services through the Department of Law shall immediately take steps to seek dismissal of pending administrative appeals and court actions concerning the issuance of certificates of need, as appropriate, under AS 18.07, as **repealed by sec. 10 of this Act** [AMENDED BY SECS. 2 - 5 OF THIS ACT] or implementation of AS 18.07."

Renumber the following bill sections accordingly.

Page 11, line 10:

Delete "Section 8"

Insert "Section 14"

Page 11, following line 10:

Insert a new bill section to read:

"*** Sec. 16.** Sections 7, 8, 10, and 13 of this Act take effect July 1, 2010."

Renumber the remaining bill sections accordingly.

Page 11, line 11:

Delete "sec. 9"

Insert "secs. 15 and 16"

Senate Bill - 245

Date: 3-18-2008

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's 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 as imposed on the health care in Alaska.

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Andrew M. Boyle
Signature: [signature]
Address: 7602 Roland rd.
Telephone: 907-452-7778 cell 907 347-9592

Senate Bill - 245 Date: 3/3/08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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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 as imposed on the health care in Alaska.

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Charles E. Walmsley Jr
Signature: [signature]
Address: 984 Senate Loop, Fairbanks AK 99712
Telephone: 907-374-9915

CONFIDENTIAL MEMORANDUM
(Not to be distributed without prior authorization)

DATE: **February 21, 2008**
TO: **Senator Bettye Davis**
FROM: **Thomas S. Obermeyer**
RE: **SB 245 – 25-GS2050\L – Explanation of revised draft amendment, 25-GS2050\L.3 (attached) by Jean Mischel, Legislative Legal Counsel, and draft amendment by Don Burrell, Aide to Senator Davis, both dated February 20, 2008 and distributed to Senate HESS Committee 2\20\08**

" An Act establishing the Alaska Health Care Commission and the Alaska Health Care Information Office; relating to health care planning and information; amending the certificate of need requirements to exclude expenditures for diagnostic imaging equipment in certain circumstances; and providing for an effective date."

---

1. 25-GS2050\L.3 should be adopted by the Senate HESS Committee as the official working document for the amendment of the "L" version of CS for SB 245( ), 25-GS2050\L (2\11\08).
2. Don Burrell only drafted on short notice and distributed to the Senate HESS Committee 2\20\08 an amendment to the "L" version of SB 245 in the absence of a draft amendment from Legislative Legal Services which was forthcoming. The Mischel draft amendment, 25-GS2050\L.1, arrived in the middle of the hearing and was also distributed on short notice with one minor typographical error in the title, indicating "Offered in the House" instead of "Senate".
3. I will distribute the revised amendment, 25-GS2050\L.3, to Committee members with a brief explanation prior to receiving and distributing Ms. Mischel's more complete forth-coming analysis.
4. 25-GS2050\L.3 (attached) comports with legislative drafting requirements and recognizes necessary changes in statutes due to the sunset provisions of the proposed amendment. As a result, it also deletes "commission" or substitutes "department" for "commission" in cross-references to the "commission."

5. 25-GS2050\L.3, p.2, lines 16-18, proposes a new section 2, AS 18.05.010(b), following Sec. 1, line 30, page 2 of the "L" version in order to conform to drafting requirements in the deletion of the language in the first page of the amendment: [BASED ON RECOMMENDATIONS OF THE ALASKA HEALTH CARE COMMISSION ESTABLISHED IN AS 18.09.010].
6. 25-GS2050\L.3 added a new Section 8 as a "repealer" of the commission by July 1, 2013 (see 25-GS2050\L.3, p. 6, lines 21-23) in order to implement the sunset provision requirement.
7. 25-GS2050\L.3 left intact the "list of procedures approved by state agencies for emergency response and treatment" ("(7)", page 7, line 26), while the Burrell version deleted this item due to vagueness, which was questioned by the Committee.
8. 25-GS2050\L.3, page 5, lines 7-9, inserted "may" for "must" concerning mandatory reporting in the database, in line 6, page 30 of "L" version.
9. 25-GS2050\L.3, page 5, lines 29-31, inserted the words, "Beginning July 1, 2009," in line 17, page 8 of the "L" version to give a year to implement changes: "Beginning July 1, 2009, a health care facility shall provide to the department. . . the following information: . . . ."
10. 25-GS2050\L.3, page 6, lines 13-16, inserted in the "L" version, page 10, after line 5 and following "department" two additional health care facilities described as "(E) a licensed pharmacy" and "(F) a physician's office."
11. 25-GS2050\L.3, page 5, lines 22-24, inserted in the "L" version, page 8 following line 5, a new paragraph to include in information disseminated "(10) a list of physicians who accept patients with Medicare coverage." Other sections are to be appropriately renumbered.

Fresenius Medical Care

FACSIMILE TRANSMITTAL SHEET

TO: Senator Bettye Davis	FROM: Jean Stevens, RVP & Mitch Long, Area Manager
COMPANY:	DATE: 3/12/2008
FAX NUMBER: 907.465.3756	TOTAL NO. OF PAGES INCLUDING COVER: 1
PHONE NUMBER:	SENDER'S REFERENCE NUMBER: 503.944.2608
RE: 6pm Phone Call	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

Dear Senator Davis,

Jean Stevens, Regional Vice President and Mitch Long, Area Manager for Fresenius Medical Care will be on this evenings call at 6pm. They may want to testify tonight.

Thank you,

Jean Stevens, Regional Vice President
Mitch Long, Area Manager

RECEIVED
MAR 12 2008

diagnostic
health Anchorage
Discover Excellence in Radiology

March 11th, 2008

AK State Capitol
Senate Health, Education and Social Services (HESS)
Juneau AK 99801-1182

Dear Senator Davis, Senator Thomas, and other Senators of the Senate HESS Committee

As an AK resident and healthcare administrator I implore you not to consider the portion of SB 245 which recommends removal of AK's Certificate of Need (CON) program. Thorough and unbiased research needs to be accomplished prior to any such action given the potential negative impact such legislation would have on the safety and quality of AK's healthcare.

I currently serve as the AK Area Administrator for Diagnostic Health and directly oversee a full modality outpatient imaging center located in midtown Anchorage[1]. As a healthcare administrator with over 15 years of experience I have grave concerns regarding current legislation in the Senate and House to eliminate or modify AK's CON program. I strongly urge unbiased research/study to determine the full short-term and long-term impact before any such action is taken. Some particulars which need to be contemplated are as follows:

- Thirty-six states still maintain some form of a Certificate of Need program. Many of the states that repealed their laws in the 80s and 90s experienced a proliferation of facility development and major medical equipment acquisition. This is particularly disturbing given that "supply" for outpatient imaging services (in the Anchorage area) is currently greater than "demand."
- Removing/modifying AK's CON program could have an extremely negative outcome with regard to quality of care as many freestanding imaging centers would not bother to hire registered technologists or ensure their facility is accredited. The American College of Radiology is conscious of this fact and thus tends to favor tighter CON restrictions for imaging services.
- Removing/modifying AK's CON program would certainly have an immediate and possibly long-term impact on the availability of skilled labor (registered technologists) causing shortages in many fields/modalities with the strong probability of negatively impacting the safety and quality of AK's healthcare.
- Market and business-driven healthcare in AK is idealistic but not a reality. It's a contradiction for some to say that "health care must be market-and business-driven, rather than restricted by government" when reality illustrates that healthcare is the most heavily regulated industry and that government dictates a significant portion of most healthcare entities reimbursements.

[1] Diagnostic Health Anchorage LP (formerly HealthSouth Diagnostic Center of Anchorage LP) has been providing full modality outpatient imaging services in a timely, quality, and cost-effective services to AK residents for over 10 years.

ASHNHA Comments on Senate Bill 245 Version "O"
Prepared by: Rod Betit, President/CEO
March 12, 2008

Madam Chairman, members of the Committee, I appreciate the opportunity to update ASHNHA's position relative to this version of SB 245.

As you will note, ASHNHA's membership supports this rewrite of SB 245. This is a much improved version of SB 245 that not only solves current CON appeals/disputes before the State, but also creates a Health Care Commission to develop solutions to Alaska's health care costs, access and quality challenges. The bill would also begins the process of creating a consumer friendly information resource to aid Alaskans in making health care decisions.

ASHNHA's POSITION ON SECTIONS CONTAINED IN SB 245(Version O):

▪ **Section 1 - Statewide Health Plan**	**SUPPORT**
▪ **Section 2 - Section 1 Amended for Commission Sunset**	**SUPPORT**
▪ **Section 3- Technical - renumbers to reflect new sections**	**SUPPORT**
▪ **Section 4 - Adds definition for Critical Access Hospital**	**SUPPORT**
▪ **Section 5 - New language clarifying imaging offices**	**SUPPORT**
▪ **Section 6/Article 1 - Creates Health Care Commission**	**SUPPORT**
▪ **Section 6/Article 2 - Creates Information Office & Reporting**	**SUPPORT**
▪ **Section 6/Article 3 - General Provisions**	**SUPPORT**
▪ **Section 7- Technical - Adds Health Commission to List**	**SUPPORT**
▪ **Section 8- Sunsets Health Care Commission in 2013**	**SUPPORT**
▪ **Section 9 - CON Transition Regulations**	**SUPPORT**
▪ **Section 10 - CON Transition Regulations**	**SUPPORT**
▪ **Section 11 - Effective Date for Section 2**	**SUPPORT**
▪ **Section 12 - More 'Effective Dates'**	**SUPPORT**
▪ **Section 13 - Commission & Reporting Effective Date**	**SUPPORT**

Sections 1 & 2 - 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.

Section 4 - Add Definition of Critical Access Hospital (CAH)

This definition would clarify which hospitals have Critical Access Hospital status. Currently there are CAH hospitals in Cordova, Dillingham, Ketchikan, Kotzebue, Nome, Petersburg, Kodiak, Seward, Valdez, Barrow, Sitka and soon in Homer.

Section 5 - Clarification of Imaging Offices Exempt from CON
Alaska statutes have always exempted physician's offices from CON and it is clear that a radiologist is a licensed physician. Most disputes under CON law have been around what types of health care settings are physician offices versus imaging centers that would be subject to CON review.

This Committee Substitute defines an imaging physician's office as an office that is at least 50% owned by radiologist physicians who are actively providing the medical procedures of interpretation and diagnosis. In other words to be granted the physician office CON exemption, the physicians in question must actually work in the practice, must own at least 50% of the practice including the equipment, and must actually interpret the images that their imaging equipment produces. If these criteria are met the office/facility would not be subject to CON review.

The Committee Substitute also limits the CON exemption for these physician practices to boroughs over 60,000 in population as a protection to smaller hospitals in smaller markets.

There is wide-spread agreement on this language within the imaging and hospital community as a fair resolution of this long standing area of disagreement. ASHNHA's members overwhelmingly support this language. Two ASHNHA members would like to see more restrictive requirements but all others support this more reasonable approach to resolving up to 80% of the appeals/lawsuits currently before the Department.

Section 6/Article 1 - Create 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. ASHNHA supports the establishment of a Commission and the diverse membership contained in this rewrite.

CSSB 245 would give the Commission broad discretion to define reporting expectations and to determine what would be useful information for the public to have. This 'permissive' authority for the Commission to develop these requirements is a strong aspect of this bill. There are many unanswered questions, missing definitions and other challenges too many to list that warrant giving the Commission this degree of latitude in developing Alaska's consumer information data base.

Section 6/Article 2 - Establish Health Care Information Office & Reporting:
ASHNHA supports the goal of providing accurate and current health care information for consumers to assist them in making health care decisions. As detailed in an earlier position paper on Version A of SB 245, ASHNHA's members have been voluntarily reporting of health

care cost, quality and charity care information for many years. All of that information is currently available to the Department could be posted to a consumer web site once actually operational.

Section 6/Article 3 - General Provisions:
Adds definitions including what entities must report under the requirements of Section 6/Article 2. This version of SB 245 makes it clear that pharmacies and physicians are subject to reporting as defined by the Commission.

Section 8 - Sunsets Health Care Commission:
Requires reauthorization of Commission in 2013 at which time the effectiveness of the Commission would be reviewed by the Legislature before its life is extended.

Section 9 & 10 - CON Transition Regulations:
Legislative Legal believes these sections are necessary even though CON repeal provisions have been removed from this version of SB 245. ASHNHA has no position on that and defers to the experts on the need for this language.

Section 11 - Effective Date for Section 2:
This section brings back the language found in Section 1 after the Commission expires in 2013 without reference to the Commission in the Department's duties from that point forward.

Section 12 - More Effective Dates:
ASHNHA has no comment on this section.

Section 13 - Commission and Reporting Effective Dates:
Information gathering and reporting 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. Clearly the July 1, 2008 effective date is simply a starting point to begin this long journey.

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

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

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

March 13, 2008

Honorable Bettye Davis, Chair
Senate HES Committee
State Capitol, Room 30
Juneau, AK 99801-1182

RECEIVED
MAR 13 2008

Senator Davis:

During the hearing of March 12, 2008, the Senate HES committee discussed an amendment to add a study of the effects of the Certificate of Need Program to **Senate Bill 300**, and questions were posed about the cost of such a study and who should manage the study.

Cost of a Certificate of Need Study:
In Fiscal Year 2005, the Legislature, through Senate Finance, contracted for an analysis of the state Medicaid program. This study cost $247,000. The Department has issued two recent Requests for Proposals for studies, with the range of $320,000 to $325,000 (the first was a comprehensive Rate setting study and the second was a long term care plan).

Management of the Study:
The amendment discussed yesterday had the Health Care Commission manage the study. The Department strongly recommends against that approach. The Commission would not start functioning until members were selected, an Executive Director was hired, etc., which would delay the RFP process. We propose two options: that the Legislature or Department contract for the study.

We recommend that the Legislature contract for the study to ensure full confidence that the study is unbiased, and meets the Legislature's expectations. The Senate HES and Finance Committees could jointly sponsor the study; which would not require a fiscal note, ensuring proposals are not targeted to a specific amount of funding.

Should the HES committee want the Department to contract for the study, we will submit a fiscal note.

Sincerely,

Sherry Hill
Assistant Commissioner for Public Affairs

cc: Senator John Cowdery, Capitol Building, Room 101
Senator Kim Elton, Capitol Building, Room 506

Senator Joe Thomas, Capitol Building, Room 510
Senator Fred Dyson, Capitol Building, Room 121
Karleen Jackson, Commissioner
Jay Butler, Chief Medical Officer
Wilda Laughlin, Special Assistant
Russell Kelly, Governor's Office, Legislative Director
Mindy Rowland, Governor's Office, Deputy Legislative Director
Anna Kim, Special Assistant
Stacie Kralie, Chief Assistant Attorney General
Deborah Behr, Chief Assistant Attorney General

Don Burrell

From: Yocom, Lauren J (GOV) [lauren.yocom@alaska.gov]
Sent: Saturday, March 29, 2008 12:02 PM
To: Don Burrell
Cc: Hill, Sherry (HSS); Laughlin, Wilda J (HSS)
Subject: SB245 Fiscal Notes
Attachments: SB245CS(HES)-DHSS-MS-03-28-08.pdf; SB245CS(HES)-DHSS-HPI-03-28-08.pdf; SB245CS(HES)-DHSS-CO-03-28-08.pdf

sponsor: Governor
requesting committee: Senate HES
date & time: no hearing scheduled in Finance yet, submitting these at the request of Senate HES

Only one (Health Planning & Infrastructure) had substantive changes. These are the changes from the LL 0050 fiscal notes (listed by component):

- Medicaid Services: deleted the graph on the last page
- Health Planning & Infrastructure: changed to indeterminate; deleted the graph on the last page

In addition, I made one correction to the Commissioner's Office FN we submitted 3-21, so I re-dated to 3-28

- Commissioner's Office: corrected Division from "Chief Medical Officer" to "Public Health"

- Laughlin

Thanks,
Lauren

Lauren Yocom
Legislative Office Assistant
Office of Governor Sarah Palin
465-4021

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS SP 245 (HES)
() Publish Date:

ID(File name) SB245CS(HES)-DHSS-MS-03-28-08
Dept. Affected: Health & Social Services
Title HEALTH CARE: PLAN/COMMISSICN/FACILITIES
RDU Health Care Services
Component Medicaid Services

Sponsor RULES BY REQUEST OF THE GOVERNOR
Requester SENATE HES
Component No. 2077

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	*		*	*	*	*	*
Miscellaneous							
TOTAL OPERATING	*	0.0	*	*	*	*	*
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	*		*	*	*	*	*
1003 GF Match	*		*	*	*	*	*
1004 GF							
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	*	0.0	*	*	*	*	*

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

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

This bill eliminates the Certificate of Need program. This fiscal note is indeterminate. Eliminating the CON program would likely increase costs to Medicaid, however the costs are unknown at this time.

This fiscal note is based on projects denied, withdrawn, or reduced as the result of the CON program which is estimated to have saved the Alaska Medicaid program approx. $3 million per year in payments for avoided capital costs (50% federal/50% GF/M). This represents 1.2% of the total project costs for these facilities.

Prepared by: William Streur, Deputy Commissioner
Phone 465-5830
Division Health Care Services
Date/Time 03/28/2008
Approved by: Karleen Jackson, Commissioner
Date 03/28/2008
Agency Department of Health and Social Services

(Revised 11/19/2007 OMB)

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS SB 245 (HES)
() Publish Date:

ID(File name) SB245CS(HES)-DHSS-HPI-03-28-08
Dept. Affected: Health & Social Services
Title HEALTH CARE: PLAN/COMMISSION/FACILITIES
RDU Departmental Support Services
Component Health Planning & Infrastucture

Sponsor RULES BY REQUEST OF THE GOVERNOR
Requester SENATE HES
Component No. 2765

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	*		*	*	*	*	*
Miscellaneous							
TOTAL OPERATING	*	0.0	*	*	*	*	*
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2008) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

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

This bill would exclude diagnostic imaging centers from Certificate of Need (CON) requirements in certain circumstances.

The potential impact on the CON program in Health Planning and Infrastructure is indeterminate (*). CON fees for some imaging centers would not be collected because CON applications would not be necessary. However, this loss of fees would not appear to be enough to affect staffing needs and costs.

Prepared by: Jay C. Butler, Chief Medical Officer
Phone 269-8045
Division Public Health
Date/Time 03/28/2008
Approved by: Karleen Jackson, Commissioner
Date 03/28/2008
Agency Department of Health and Social Services

(Revised 11/19/2007 OMB)

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS SB 245 (HES)
() Publish Date:

ID(File name) SB245CS(HES)-DHSS-CO-03-28-08
Dept. Affected: Health & Social Services
Title HEALTH CARE: PLAN/COMMISSION/FACILITIES
RDU Departmental Support Services
Component Commissioner's Office
Sponsor RULES BY REQUEST OF THE GOVERNOR
Requester SENATE HES
Component No. 317

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual	325.0						
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**325.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	325.0						
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	**325.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

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

CS SB245 (HES) requires the Department of Health and Social Services (DHSS) to contract for an independent study of the efficacy of the Certificate of Need (CON) program in Alaska. This fiscal note is an estimate based on two recent studies contracted out by the department. It is assumed the contractor would interact with the CON program to receive data and other pertinent information -- and that no work for the actual study would be conducted in DHSS. It is assumed the study would be completed in FY2009. One example study was a comprehensive rate-setting study for home and community-based services costing $325.0, which included a review of regulations and statutes, development of a new rate-setting system and assisting with the transition. The other was a Request for Proposal (RFP) for a Long Term Care Plan, requiring a contractor with extensive experience in analyzing health care systems at a state or regional level. The $320.0 RFP has generated several responsive bids.

Prepared by: Jay C. Butler, Chief Medical Officer
Phone 269-8045
Division Public Health
Date/Time 03/21/2008
Approved by: Karleen Jackson, Commissioner
Date 03/28/2008
Agency Department of Health and Social Services

(Revised 11/19/2007 OMB)

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

March 14, 2008

Honorable Bettye Davis
Chair, Senate Health, Education and Social Services Committee
State Senate
State Capitol, Room 30
Juneau, AK 99801-1182

Transmitted by email: Senator_Bettye_Davis@legis.state.ak.us

RE: Work Draft CS for SB245 (version 0) - Alaska Health Care Commission and Alaska Health Care Information Office

Dear Senator Davis:

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

ASMA supports the concept of the establishment of the Alaska Health Care Commission (AHCC). However, ASMA might recommend that more than one seat be slotted for physicians. ASMA believes the AHCC purpose would be better served by physician members from diverse geographic areas as well as physicians representing different medical specialties.

ASMA appreciates and understands what SB245 is attempting to accomplish by the formation of the Alaska Health Care Information Office (AHCIO) and with the establishment of the internet based information database. However, ASMA can not support the provisions in SB245 creating the AHCIO and the data base for a host of reasons including drafting created questions, scope of its application, practical issues, and potential serious legal issues. Those concerns are summarized as follows:

- **Drafting/Definition Issues**
  - **No definition of "physician office"**
  - **"physician office" included in the definition of a facility which creates confusion in applicable provisions**
  - **No definition of a "medical procedure" (i.e. no common nomenclature such as CPT codes)**
  - **No definition of "health care providers"**
  - **No definition of "Types" of insurance**
  - **No definition of "amounts" of insurance**
  - **No definition of "actions" taken by Regulatory Agencies (e.g. after formal adjudication?)**
- **Legal Issues**
  - **Impairment of Contract**
  - **ERISA Pre-emption**
  - **Equal Application (e.g. dentists, chiropractors, advanced nurse practitioners, and optometrists not covered by SB245)**
  - **Confidentiality of Underlying Data which is reported**
- **Practical and Cost Issues**
  - **Frequency of Required Reporting May Impact Cost to Physicians as well as the Department**
  - **Unclear what "the costs to consumer" actually means (Does "actual" mean the actual cost after deductibles, co-pays, or other limitations in the insurance coverage?)**

(ASMA's comments will generally apply to physicians but some may be applicable to other health care professionals as well.)

The more detailed comments relating to the above summary follow.

First, the way in which the provisions creating AS18.09.100 through AS18.09.990, by including in the definitions of "health care facility" (AS18.09.990 (4)) a "physician's office" (AS18.09.990 (4)(F)), creates non-sensical practical situations. For example, what does it mean in AS18.09.120 (a) (1) (p.10 lines 9-10) regarding a physician office to split costs between a facility component and a physician component. This is a provision more suited to in-patient hospital care. Please also note the term "physician office" is not defined. Does this mean each individual physician practice, each individual licensed physician, etc?

AS18.09.110 (a) (p.8 lines 11-12) states the Department "may" require health care facilities to report data. This states the Department has discretion. Yet AS18.09.120 (a) (p.10 lines 6-7) requires mandatory reporting beginning July 1, 2009. Does this mean the Department has discretion only between July 1, 2008 and July 2, 2009 as far as requiring reporting of the required data? It would also seem to be a daunting task for the Department to review the data individually with each physician licensed in this state.

AS18.09.110 (b) (2) (E) (p.8 lines 25-27) requires that the data base has a listing of all licensed "health care providers" in the State. The term "health care providers" is not defined but could include those not covered by the provisions of this bill. For example, dentists, advance nurse practitioners, chiropractors, optometrists, etc. could fall in this category. Why would these health care providers not be covered by the requirements of SB245 while others are by being defined as a "health care facility"? This would also appear to be an unequal application of the law should SB245 be passed in its current form, and may not provide for the collection of data from other health care professionals that could be important to the consumers of health care.

AS18.09.110 (b) (4) (p.9 - lines 2-5) requires that the data base include a list of the 100 most commonly conducted medical procedures. The terms "medical procedure" is not defined and needs to be so common nomenclature is used - for example CPT codes for physicians. It is not specified but it is presumed that the reporting health care facilities, as defined, would need to report data on all the medical procedures provided. It could be the most commonly conducted procedures would be the lowest cost procedures. Potentially, the most expensive, least conducted, rare procedures would never be included in the data base. Another requirement of this provision, as well as AS18.09.120 (a) (2) (p.10 line 12), requires respectively that the data base include and the health care facility provide the "cash" and "negotiated" price of a procedure. A "negotiated" price may, indeed, be the result of a contract entered into by a physician and a health insurance company. For competitive reasons, neither the physician nor the health insurance company may not want the terms of such documents disclosed. (Due to the small size of the health care community in Alaska, de-identified data may not solve this problem). This could provide for a legal issue surrounding impairment of contract. At a minimum, it could also result in a physician opting not to provide the data and have the department post on the data base that physician's failure to provide the information. (It is also possible that the terms of the contract could prohibit such disclosure). Another more serious issue is also raised.

The presumption, in the absence of any specific language in SB245, is that a physician would be required to report the "negotiated" price pursuant to a contract with a health insurer for fully insured plans as well as with self-insured plans. Having such a requirement apply to self-insured plans may be pre-empted by federal law and could not apply. The federal law is the Employee Retirement Income Security Act of 1974 (commonly known as ERISA). ERISA pre-emption issues are very complex and ASMA is not aware of any attorneys who are experts who live in Alaska. If ERISA pre-empts such reporting for physicians for self-insured plans, the data base's value would seemingly be greatly diminished, as reportedly a significant number of Alaskan's have health plans that are self-insured.

AS18.09.110 (b) (12) (p.9 lines 25-26) requires that actions taken by state of federal agencies be included in the data base. It is not clear if this requirement means that "actions" are those that are after final adjudication or if this includes initial allegations. It is recommended that a reported "action" be an action that has been fully adjudicated.

AS18.09.120 (a) (p.10, lines 5-7) addresses a reporting schedule set by the Department. The costs of reporting this data will vary with how often the data must be reported. Legislative guidance would be welcomed as to frequency of reporting. Should it be monthly, quarterly, semi-annually, annually, or whenever any price changes? The frequency also impacts the Department costs as well in part because it is required to review the data that goes onto the web site with those persons who provided it.

AS18.09.120 (a) (1) (p.10 lines 9-10) requires that physicians report "costs to and bills payable by the consumer...". AS18.09.990 (2) defines "costs to the consumer" as the actual price paid by the consumer. This language is unclear as to exactly what would need to be reported. Does this mean that what the consumer pays after the health plan pays (i.e. out of pocket after deductibles, co-pays, limitations, etc)? If so, this could be a daunting if not impossible task for the physician to determine because the amount owed changes as deductibles are met, co-pays decreased, to include just a few of the variables.

AS18.09.120 (a) (2) (p.10, lines 11-12). This provision requires a physician to report the "...types and amounts of insurance..." accepted. The "types" of insurance should probably be defined even though it appears to be clear what is meant - private health insurance, Medicaid, Medicare, Worker's Compensation, etc. What is not known and needs definition is the term "amounts of insurance". Perhaps the insurance industry may provide you guidance in this area as ASMA has no idea of what this means.

Generally, there is no language that addresses the confidentiality of the underlying data - de-identified or not. Obviously the data on the internet would be available for all to see. But, the question remains if the underlying data in the Department's possession is subject to public inspection via a freedom of information request or other means. Transparency is usually a good element but it must not be at the cost of appropriate privacy and constitutional protection.

Due to the complex legal and practical issues raised, ASMA believes a great deal of work is necessary. ASMA does not see how these issues can be thoroughly researched and addressed in the time remaining in this session. ASMA would support the creation of the Alaska Health Care Commission and would commit to providing the names of a sufficient number of physicians to accomplish its work. Furthermore, it is recommended that the Alaska Health Information Office and the development of an appropriate data base not be addressed at this time in legislation. ASMA would suggest that the Alaska Health Care Commission itself be given the direct charge to develop a recommendation as to the formation of the Alaska Health Information Office and the development of a database in a manner that addresses the issues raised by ASMA and, certainly, other stakeholders.

Sincerely,



By: J. Ross Tanner, DO, President
For: The Alaska State Medical Association

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Senator Bettye Davis
Senate HESS Committee

Senate Bill No. 245

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date."

Work Drafts

1/19/08	
25-GS2050\A –	Governor's Bill with Amendments, Sectional Analysis and Fiscal Notes
1/29/08	
25-GS2050\C –	Senate CS to incorporate Governor's Amendments
1/30/08	
25-GH2050\E -	CS for House Bill 337(HES) with notes from HSS
2/5/08	
25-GS2050\M -	Senate CS amending "E" version and adding 2 more public members
2/08/08	
GS2050K -	Senate CS amending "M" version with changes
2/11/08	
GS2050\L -	Senate CS amending "K" version with changes
3/05/08	
25-GS2050\O -	"O" version amending "L" and L.3 Amendment
3/20/08	
25-GS2050\V -	"V" version adding Study by Dept
3/06/08	
25-LS1599\A -	Senate Bill 300 removed CON sect., leaves Commission; info office; information
3/28/08 -	"N" Voted out of Committee with amendments is final "HESS" version

25-GS2050\L
Mischel
2/11/08

CS FOR SENATE BILL NO. 245( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; amending the certificate of need requirements to exclude expenditures for diagnostic imaging equipment in certain circumstances; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read.

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to

develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

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

(a) Except as provided in **(e), (d), and (f)** [(c) AND (d)] of this section, a person may not make an expenditure of $1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the department:

(1) construction of a health care facility;

(2) alteration of the bed capacity of a health care facility; or

(3) addition of a category of health services provided by a health care facility

*** Sec. 3.** AS 18.07.031(e) is amended to read:

(e) In

(1) (a) of this section, "expenditure" includes the purchase of property occupied by or the equipment required for the health care facility and the net present value of a lease for space occupied by or the equipment required for the health care facility; "expenditure" does not include costs associated with routine maintenance and replacement of equipment at an existing health care facility;

(2) (f) of this section, "critical access hospital" refers to a facility designated as a critical access hospital by the department by regulatory authority exercised under AS 18.05 or AS 18.20.

*** Sec. 4.** AS 18.07.031 is amended by adding a new subsection to read:

(f) Notwithstanding the limitations in (a) of this section, a person may make an expenditure of $1,000,000 or more for diagnostic imaging equipment without authorization under the terms of a certificate of need issued by the department if the equipment is used in a health care facility that

(1) is located in a

(A) borough with a population of 60,000 or more; and

(B) a city that does not have a facility designated by the department as a critical access hospital; and

(2) has at least a 50 percent ownership by one or more physicians licensed in the state who are qualified to interpret, and actually interpret, diagnostic images produced by the equipment in the facility

*** Sec. 5.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care Planning and Information.

DRAFT NOT INTENDED FOR INTRODUCTION

Article 1. Alaska Health Care Commission; State Health Plan.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purposes of the commission are

(1) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state; and

(2) to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Sec. 18.09.020. Composition; chair. (a) The commission consists of 13 members as follows:

(1) the state officer assigned the duties of medical director for the department;

(2) one member representing the Department of Administration, appointed by the commissioner of administration;

(3) one member representing the Department of Commerce, Community, and Economic Development, appointed by the commissioner of commerce, community, and economic development;

(4) one member representing the Department of Labor and Workforce Development, appointed by the commissioner of labor and workforce development;

(5) six public members, appointed by the governor; one of the members appointed under this paragraph must be a small business owner in the state;

(6) one member from the house of representatives, appointed by the speaker of the house;

(7) one member from the senate, appointed by the president of the senate; and

(8) one member representing the Office of the Governor.

(b) The department's representative appointed under (a)(1) of this section shall serve as chair of the commission.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(a)(5) serve for staggered terms of three years.

New Text Underlined [DELETED TEXT BRACKETED]

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) The governor may remove a public member of the commission from office only for cause.

Sec. 18.09.040. Executive director. The commission shall employ an executive director who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing proceedings and other activities, including provisions concerning a quorum to transact commission business and other aspects of procedure; frequency and location of meetings; and establishment, functions, and membership of committees.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for

(A) encouraging personal responsibility in prevention and healthy living for all residents of the state;

(B) reducing health care costs for all residents of the state to below the national average;

(C) ensuring access in communities to safe water and wastewater systems;

(D) developing a sustainable health care workforce in the state;

(E) ensuring access to quality health care for all residents of the

state; and

(F) increasing the number of residents of the state who are covered by insurance for health care services.

(b) The commission shall review and approve health care information for placement on the department's database developed under AS 18.09.110 and establish a schedule for implementation of the database and reporting requirements under AS 18.09.120.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities.

Sec. 18.09.080. Compensation, per diem, and expenses. A public member appointed to the commission under AS 18.09.020(a)(5) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

Article 2. Alaska Health Care Information Office.

Sec. 18.09.100. Office. The Alaska health care information office is established in the department. The purpose of the office is to improve access by residents of the state to consistently updated

(1) information about health care facilities to aid consumers of health care services of health care facilities in the state; and

(2) information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110. Dissemination of information. (a) The department shall establish and maintain an information database on the Internet of information about all health care facilities in the state to provide objective, unbiased, and factually based information on health care facilities in the state. The department may require those health care facilities to provide information in a standard form or format to the department for placement in the database. Before information is placed on the database, the commission shall review the information for accuracy.

(b) The database developed under (a) of this section must include the following

(1) a list of preferred drugs approved by the department for reimbursement by the department;

(2) a complete list, organized by region and address, of

(A) health facilities located in the state;

(B) licensed pharmacists and pharmacies located in the state;

(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state;

(G) public assistance offices of the department;

(3) a list of the 100 most commonly prescribed medications in the state and the source and price, updated monthly, of the medications;

(4) a list of the 100 most commonly conducted medical procedures in the state, organized by the cash and negotiated price of the procedure at available providers and insurers, updated annually; the list must include medical procedures covered by workers' compensation under AS 23.30;

(5) available hospital ratings, including the rates of hospital acquired infections and mortality occurring at each hospital located in the state;

(6) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, that includes the location of available sites that provide care and treatment related to those issues;

(7) a list of procedures approved by state agencies for emergency response and treatment;

(8) disease management support information;

(9) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

New Text Underlined [DELETED TEXT BRACKETED]

(B) links to Internet websites for purchasing insurance policies;

(C) an explanation of mandatory and optional insurance coverage;

(10) a list of primary care clinics that cater to uninsured and self-pay patients; and

(11) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility.

(c) The department may contract with a private entity to provide services and information required under (a) of this section.

(d) The department shall develop and consistently update an Internet website to provide residents of the state timely and accurate information regarding prevention and healthy living.

(e) The department shall post and make available information related to the commission, including the commission's annual reports under AS 18.09.070(e).

Sec. 18.09.120. Mandatory reporting. (a) A health care facility shall provide to the department, based on a schedule set by the commission under AS 18.09.070(b), the following information related to the facility's health care services for placement in the database developed under AS 18.09.110:

(1) information on costs to the consumer for health care services;

(2) types of insurance and payment accepted by the health care facility for health care services;

(3) each location where the health care facility operates, and the hours of operation;

(4) the types and scope of health care services offered at the health care facility;

(5) the Internet address of any Internet website of the health care facility the purpose of which is to provide factual information to aid the consumer;

(6) any other readily accessible information that the department determines would help the consumer to make informed decisions about the health care

facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of a failure to report under (a) of this section and give the health care facility an opportunity to contest or cure the failure. If the health care facility does not promptly cure the failure, the department shall post the notice of failure on the database developed under AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide to the commission for placement on the database developed under AS 18.09.110 information regarding an adverse action taken against a health care facility in the state or against a licensed professional practicing in a health care facility in the state; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "costs to the consumer" means actual price paid by the consumer for health care services;

(3) "department" means the Department of Health and Social Services;

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing

services in the state;

(C) a provider of a home and community based waiver service that is certified under regulations adopted by the department;

(D) a provider of personal care services that is certified under regulations adopted by the department.

*** Sec. 6.** AS 39.25.120(e)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

*** Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. Sections 2 - 4 of this Act apply to health care facilities in existence or proposed on or after the effective date of this Act. A decision of the Department of Health and Social Services made before the effective date of this Act denying or granting a certificate of need that was applied for or issued for a health care facility described in AS 18.07.031(f),

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added by sec. 4 of this Act, shall be void and unnecessary. A pending application for a certificate of need for a health care facility described in AS 18.07.031(f), added by sec. 4 of this Act, shall be returned to the applicant.

*** Sec. 8.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 9.** Section 8 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 10.** Except as provided in sec. 9 of this Act, this Act takes effect July 1, 2008.

25-GS2050\O
Mischel
3/5/08

CS FOR SENATE BILL NO. 245( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; amending the certificate of need requirements to exclude expenditures for diagnostic imaging equipment in certain circumstances; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to

develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

*** Sec. 2.** AS 18.05.010(b), as amended by sec. 1 of this Act, is amended to read:

(b) In performing its duties under this chapter, AS 18.09, and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 [BASED ON RECOMMENDATIONS OF THE ALASKA HEALTH CARE COMMISSION ESTABLISHED IN AS 18.09.010]; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify. assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening

services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

*** Sec. 3.** AS 18.07.031(a) is amended to read:

(a) Except as provided in **(c), (d), and (f)** [(c) AND (d)] of this section, a person may not make an expenditure of $1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the department:

(1) construction of a health care facility;

(2) alteration of the bed capacity of a health care facility; or

(3) addition of a category of health services provided by a health care facility.

*** Sec. 4.** AS 18.07.031(e) is amended to read:

(e) In [(a) OF] this section,

(1) "expenditure" includes the purchase of property occupied by or the equipment required for the health care facility and the net present value of a lease for space occupied by or the equipment required for the health care facility; "expenditure" does not include costs associated with routine maintenance and replacement of equipment at an existing health care facility**;**

(2) "critical access hospital" means a facility designated as a critical access hospital by the department by regulatory authority exercised under AS 18.05 or AS 18.20.

*** Sec. 5.** AS 18.07.031 is amended by adding a new subsection to read:

(f) Notwithstanding the limitations in (a) of this section, a person may make an expenditure of $1,000,000 or more for diagnostic imaging equipment without authorization under the terms of a certificate of need issued by the department if the equipment is used in a health care facility that

(1) is located in a

(A) borough with a population of 60,000 or more; and

(B) a city that does not have a facility designated by the department as a critical access hospital; and

(2) has at least a 50 percent ownership by one or more physicians licensed in the state who are qualified to interpret, and actually interpret, diagnostic images produced by the equipment in the facility.

*** Sec. 6.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care Planning and Information.

Article 1. Alaska Health Care Commission; State Health Plan.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purposes of the commission are

(1) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state;

(2) to review and approve the department's plan for a reporting data system, including the type of reporting entity or person, and the timing of reporting; and

(3) to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Sec. 18.09.020. Composition; chair. (a) The commission consists of 15 members, as follows:

(1) the state officer assigned the duties of medical director for the department;

(2) one member representing the governor and appointed by the governor;

(3) one member who is a member of the Alaska Commission on Aging;

(4) three public members, in addition to members appointed under (5), (8), and (9) of this subsection, appointed by the governor; one of the members appointed under this paragraph must be a small business owner in the state;

(5) three public members who are health care providers, appointed by the governor, as follows: one representing hospitals, one representing physicians, and one representing mental health;

(6) two members from the house of representatives appointed by the speaker of the house of representatives;

(7) two members from the senate appointed by the president of the senate;

(8) one public member representing the Alaska tribal health care system appointed by the governor; and

(9) one public member representing health care insurers appointed by the governor.

(b) The medical director appointed under (a)(1) of this section shall serve as chair of the commission.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(a)(4), (5), (8), and (9) serve for staggered terms of five years.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) The governor may remove a public member of the commission from office only for cause.

Sec. 18.09.040. Executive director. The commission shall employ an executive director with appropriate health care policy experience who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing

proceedings and other activities, including provisions concerning a quorum to transact commission business and other aspects of procedure; frequency and location of meetings; and establishment, functions, and membership of committees.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for

(A) encouraging personal responsibility in prevention and healthy living for all residents of the state;

(B) reducing the rate of growth in health care costs for all residents of the state;

(C) improving access in communities to safe water and wastewater systems;

(D) developing a sustainable health care workforce in the state;

(E) improving access to quality health care for all residents of the state and increasing the number of residents of the state who are covered by insurance for health care services.

(b) The commission shall review and approve health care information for placement on the department's database developed under AS 18.09.110 and establish a schedule for implementation of the database and reporting requirements under AS 18.09.120.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities.

Sec. 18.09.080. Compensation, per diem, and expenses. A public member appointed to the commission under AS 18.09.020(a)(4), (5), (8), or (9) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

Article 2. Alaska Health Care Information Office.

Sec. 18.09.100. Office. The Alaska health care information office is established in the department. The purpose of the office is to improve access by residents of the state to consistently updated

(1) information about health care services, price, and quality to aid consumers in making health care decisions; and

(2) information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110. Dissemination of information. (a) The department shall establish and maintain an information database on the Internet of information about health care facilities in the state to provide objective, unbiased, and factually based information on health care services in the state. The department may require those health care facilities to provide information in a standard form or format to the department for placement in the database. Before information is placed on the database, the department shall review the information with the health care facility for accuracy.

(b) The database developed under (a) of this section must include the following:

(1) a list of preferred drugs approved by the department for reimbursement by the department;

(2) a complete list, organized by region and address, of

(A) health care facilities located in the state;

(B) licensed pharmacists and pharmacies located in the state;

(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state;

(G) public assistance offices of the department;

(3) a list of the 100 most commonly prescribed medications in the state

and the source and price, updated monthly, of the medications;

(4) a list of the 100 most commonly conducted medical procedures in the state, organized by the cash and negotiated price of the procedure at available providers and insurers, updated annually; the list must include medical procedures covered by workers' compensation under AS 23.30;

(5) available hospital ratings, including the rates of hospital acquired infections and mortality occurring at each hospital located in the state;

(6) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, that includes the location of available sites that provide care and treatment related to those issues;

(7) a list of procedures approved by state agencies for emergency response and treatment;

(8) disease management support information;

(9) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

(B) links to Internet websites for purchasing insurance policies;

(C) an explanation of mandatory and optional insurance coverage;

(10) a list of primary care clinics that cater to uninsured and self-pay patients;

(11) a list of physicians who accept patients with Medicare coverage; and

(12) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility.

(c) The department may contract with a private entity to provide services and information required under (a) of this section.

(d) The department shall develop and consistently update an Internet website

to provide residents of the state timely and accurate information regarding prevention and healthy living.

(e) The department shall post and make available information related to the commission, including the commission's annual reports under AS 18.09.070(c).

Sec. 18.09.120. Mandatory reporting. (a) Beginning July 1, 2009, a health care facility shall provide to the department, based on a schedule set by the department, the following information related to the facility's health care services for placement in the database developed under AS 18.09.110:

(1) information on costs to and bills payable by the consumer for health care services that include both facility and physician components of care;

(2) types and amounts of insurance and other payments accepted by the health care facility for health care services, including cash and negotiated prices;

(3) each location where the health care facility operates, and the hours of operation;

(4) the types and scope of health care services offered at the health care facility;

(5) the Internet address of any Internet website of the health care facility the purpose of which is to provide factual information to aid the consumer;

(6) any other readily accessible information that the department determines would help the consumer to make informed decisions about the health care facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of a failure to report under (a) of this section and give the health care facility an opportunity to contest or cure the failure. If the health care facility does not promptly cure the failure, the department shall post the notice of failure on the database developed under AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of

Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide to the department for placement on the database developed under AS 18.09.110 information regarding an adverse action taken against a health care facility in the state or against a licensed professional practicing in a health care facility in the state; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "costs to the consumer" means actual price paid by the consumer for health care services;

(3) "department" means the Department of Health and Social Services;

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing services in the state;

(C) a provider of a home and community based waiver service that is certified under regulations adopted by the department;

(D) a provider of personal care services that is certified under regulations adopted by the department;

(E) a licensed pharmacy; and

(F) a physician's office.

* **Sec. 7.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

*** Sec. 8.** AS 18.09.010, 18.09.020, 18.09.030, 18.09.040, 18.09.050, 18.09.060, 18.09.070, 18.09.080, 18.09.110(e), 18.09.130(2), 18.09.990(1); and AS 39.25.120(c)(7)(P) are repealed July 1, 2013.

*** Sec. 9.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. Sections 3 - 5 of this Act apply to health care facilities in existence or proposed on or after the effective date of secs. 3 - 5 of this Act. A decision of the Department of Health and Social Services made before the effective date of secs. 3 - 5 this Act denying or granting a certificate of need that was applied for or issued for a health care facility described in AS 18.07.031(f), added by sec. 5 of this Act, shall be void and unnecessary. A pending application for a certificate of need for a health care facility described in AS 18.07.031(f), added by sec. 5 of this Act, shall be returned to the applicant.

*** Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may

proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 11.** Section 2 of this Act takes effect July 1, 2013.

*** Sec. 12.** Sections 3 - 5, 9, and 10 of this Act take effect immediately under AS 01.10.070(c).

*** Sec. 13.** Except as provided in secs. 11 and 12 of this Act, this Act takes effect July 1, 2008.

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3/20/08

CS FOR SENATE BILL NO. 245( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; amending the certificate of need requirements to exclude expenditures for diagnostic imaging equipment in certain circumstances; providing for a study of the certificate of need program; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health

issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers,

within the public health system to achieve the mission of public health.

* **Sec. 2.** AS 18.05.010(b), as amended by sec. 1 of this Act, is amended to read:

(b) In performing its duties under this chapter, AS 18.09, and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 [BASED ON RECOMMENDATIONS OF THE ALASKA HEALTH CARE COMMISSION ESTABLISHED IN AS 18.09.010]; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and

episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

*** Sec. 3.** AS 18.07.031(a) is amended to read:

(a) Except as provided in **(c), (d), and (f)** [(c) AND (d)] of this section, a person may not make an expenditure of $1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the department:

(1) construction of a health care facility;

(2) alteration of the bed capacity of a health care facility; or

(3) addition of a category of health services provided by a health care facility.

*** Sec. 4.** AS 18.07.031(e) is amended to read:

(e) In [(a) OF] this section,

(1) "expenditure" includes the purchase of property occupied by or the equipment required for the health care facility and the net present value of a lease for space occupied by or the equipment required for the health care facility; "expenditure" does not include costs associated with routine maintenance and replacement of equipment at an existing health care facility;

(2) "critical access hospital" means a facility designated as a critical access hospital by the department by regulatory authority exercised under AS 18.05 or AS 18.20.

*** Sec. 5.** AS 18.07.031 is amended by adding a new subsection to read:

(f) Notwithstanding the limitations in (a) of this section, a person may make an expenditure of $1,000,000 or more for diagnostic imaging equipment without authorization under the terms of a certificate of need issued by the department if the

equipment is used in a health care facility that

(1) is located in a

(A) borough with a population of 60,000 or more; and

(B) a city that does not have a facility designated by the department as a critical access hospital; and

(2) has at least a 50 percent ownership by one or more physicians licensed in the state who are qualified to interpret, and actually interpret, diagnostic images produced by the equipment in the facility.

* **Sec. 6.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care Planning and Information.

Article 1. Alaska Health Care Commission; State Health Plan.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purposes of the commission are

(1) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state;

(2) to review and approve the department's plan for a reporting data system, including the type of reporting entity or person, and the timing of reporting; and

(3) to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Sec. 18.09.020. Composition; chair. (a) The commission consists of 15 members, as follows:

(1) the state officer assigned the duties of medical director for the department;

(2) one member representing the governor and appointed by the governor;

(3) one member who is a member of the Alaska Commission on Aging;

(4) three public members, in addition to members appointed under (5),

(8), and (9) of this subsection, appointed by the governor; one of the members appointed under this paragraph must be a small business owner in the state;

(5) three public members who are health care providers, appointed by the governor, as follows: one representing hospitals, one representing physicians, and one representing mental health;

(6) two members from the house of representatives appointed by the speaker of the house of representatives;

(7) two members from the senate appointed by the president of the senate;

(8) one public member representing the Alaska tribal health care system appointed by the governor; and

(9) one public member representing health care insurers appointed by the governor.

(b) The medical director appointed under (a)(1) of this section shall serve as chair of the commission.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(a)(4), (5), (8), and (9) serve for staggered terms of five years.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) The governor may remove a public member of the commission from office only for cause.

Sec. 18.09.040. Executive director. The commission shall employ an executive director with appropriate health care policy experience who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing proceedings and other activities, including provisions concerning a quorum to transact commission business and other aspects of procedure; frequency and location of meetings; and establishment, functions, and membership of committees.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for

(A) encouraging personal responsibility in prevention and healthy living for all residents of the state;

(B) reducing the rate of growth in health care costs for all residents of the state;

(C) improving access in communities to safe water and wastewater systems;

(D) developing a sustainable health care workforce in the state;

(E) improving access to quality health care for all residents of the state and increasing the number of residents of the state who are covered by insurance for health care services.

(b) The commission shall review and approve health care information for placement on the department's database developed under AS 18.09.110 and establish a schedule for implementation of the database and reporting requirements under AS 18.09.120.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities.

Sec. 18.09.080. Compensation, per diem, and expenses. A public member appointed to the commission under AS 18.09.020(a)(4), (5), (8), or (9) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses

authorized by law for boards and commissions under AS 39.20.180.

Article 2. Alaska Health Care Information Office.

Sec. 18.09.100. Office. The Alaska health care information office is established in the department. The purpose of the office is to improve access by residents of the state to consistently updated

(1) information about health care services, price, and quality to aid consumers in making health care decisions; and

(2) information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110. Dissemination of information. (a) The department shall establish and maintain an information database on the Internet of information about health care facilities in the state to provide objective, unbiased, and factually based information on health care services in the state. The department may require those health care facilities to provide information in a standard form or format to the department for placement in the database. Before information is placed on the database, the department shall review the information with the health care facility for accuracy.

(b) The database developed under (a) of this section must include the following:

(1) a list of preferred drugs approved by the department for reimbursement by the department;

(2) a complete list, organized by region and address, of

(A) health care facilities located in the state;

(B) licensed pharmacists and pharmacies located in the state;

(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state;

(G) public assistance offices of the department;

(3) a list of the 100 most commonly prescribed medications in the state and the source and price, updated monthly, of the medications;

(4) a list of the 100 most commonly conducted medical procedures in the state, organized by the cash and negotiated price of the procedure at available providers and insurers, updated annually; the list must include medical procedures covered by workers' compensation under AS 23.30;

(5) available hospital ratings, including the rates of hospital acquired infections and mortality occurring at each hospital located in the state;

(6) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, that includes the location of available sites that provide care and treatment related to those issues;

(7) a list of procedures approved by state agencies for emergency response and treatment;

(8) disease management support information;

(9) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

(B) links to Internet websites for purchasing insurance policies;

(C) an explanation of mandatory and optional insurance coverage;

(10) a list of primary care clinics that cater to uninsured and self-pay patients;

(11) a list of physicians who accept patients with Medicare coverage; and

(12) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility.

(c) The department may contract with a private entity to provide services and

information required under (a) of this section.

(d) The department shall develop and consistently update an Internet website to provide residents of the state timely and accurate information regarding prevention and healthy living.

(e) The department shall post and make available information related to the commission, including the commission's annual reports under AS 18.09.070(c).

Sec. 18.09.120. Mandatory reporting. (a) Beginning July 1, 2009, a health care facility shall provide to the department, based on a schedule set by the department, the following information related to the facility's health care services for placement in the database developed under AS 18.09.110:

(1) information on costs to and bills payable by the consumer for health care services that include both facility and physician components of care;

(2) types and amounts of insurance and other payments accepted by the health care facility for health care services, including cash and negotiated prices;

(3) each location where the health care facility operates, and the hours of operation;

(4) the types and scope of health care services offered at the health care facility;

(5) the Internet address of any Internet website of the health care facility the purpose of which is to provide factual information to aid the consumer;

(6) any other readily accessible information that the department determines would help the consumer to make informed decisions about the health care facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of a failure to report under (a) of this section and give the health care facility an opportunity to contest or cure the failure. If the health care facility does not promptly cure the failure, the department shall post the notice of failure on the database developed under

AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide to the department for placement on the database developed under AS 18.09.110 information regarding an adverse action taken against a health care facility in the state or against a licensed professional practicing in a health care facility in the state; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "costs to the consumer" means actual price paid by the consumer for health care services;

(3) "department" means the Department of Health and Social Services;

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing services in the state;

(C) a provider of a home and community based waiver service that is certified under regulations adopted by the department;

(D) a provider of personal care services that is certified under regulations adopted by the department;

(E) a licensed pharmacy; and

(F) a physician's office.

* **Sec. 7.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or

commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission:

*** Sec. 8.** AS 18.09.010, 18.09.020, 18.09.030, 18.09.040, 18.09.050, 18.09.060, 18.09.070, 18.09.080, 18.09.110(e), 18.09.130(2), 18.09.990(1); and AS 39.25.120(c)(7)(P) are repealed July 1, 2013.

*** Sec. 9.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. Sections 3 - 5 of this Act apply to health care facilities in existence or proposed on or after the effective date of secs. 3 - 5 of this Act. A decision of the Department of Health and Social Services made before the effective date of secs. 3 - 5 this Act denying or granting a certificate of need that was applied for or issued for a health care facility described in AS 18.07.031(f), added by sec. 5 of this Act, shall be void and unnecessary. A pending application for a certificate of need for a health care facility described in AS 18.07.031(f), added by sec. 5 of this Act, shall be returned to the applicant.

*** Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 11.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CERTIFICATE OF NEED STUDY. The Department of Health and Social Services shall contract with an entity that has no financial interest in health care services to conduct a comprehensive study of the effects of the certificate of need program in the state. The department shall provide a copy of the study to the legislature.

*** Sec. 12.** Section 2 of this Act takes effect July 1, 2013.

*** Sec. 13.** Sections 3 - 5, 9, 10, and 11 of this Act take effect immediately under AS 01.10.070(c).

*** Sec. 14.** Except as provided in secs. 12 and 13 of this Act, this Act takes effect July 1, 2008.

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/08

FURTHER: Finance

Date of 5-Day Notice: 1/17/08
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/31/08

Health, Education and Social Services Committee considered

SENATE BILL NO. 245

SB 245 HEALTH CARE: PLAN/COMMISSION/FACILITIES

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date."

and recommends:

[✓] be **replaced** with [ ] **SCS** or [✓] **CS** SB 245 (HES)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[✓] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
DHSS/2077	3/28/08		✓		
DHSS/2786	3/28/08		✓		
DHSS/317	3/28/08	✓			

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
HSS (2894)	1/17/08	✓			2
HSS (2900)	1/18	✓			1

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	DO REC	AMEND
	Elton			✓	
	Thomas	✓			
	Dyson			✓	
	Coghill		✓		
CHAIR: Betty Davis	DAVIS	✓			