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TABLE 12 *Percent of Persons Charged With Drunkenness and Other Breaches of the Liquor Control Act (LCA) in Toronto, 1968–1977—Under 18 Years of Age*

	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977
LCA—Drunk	6.32	1.98	.26	2.65	6.78	7.60	8.97	0.64	1.40	1.40
LCA—Other[a]	52.95	45.94	39.87	50.09	39.58	39.50	39.19	23.56	21.82	28.95

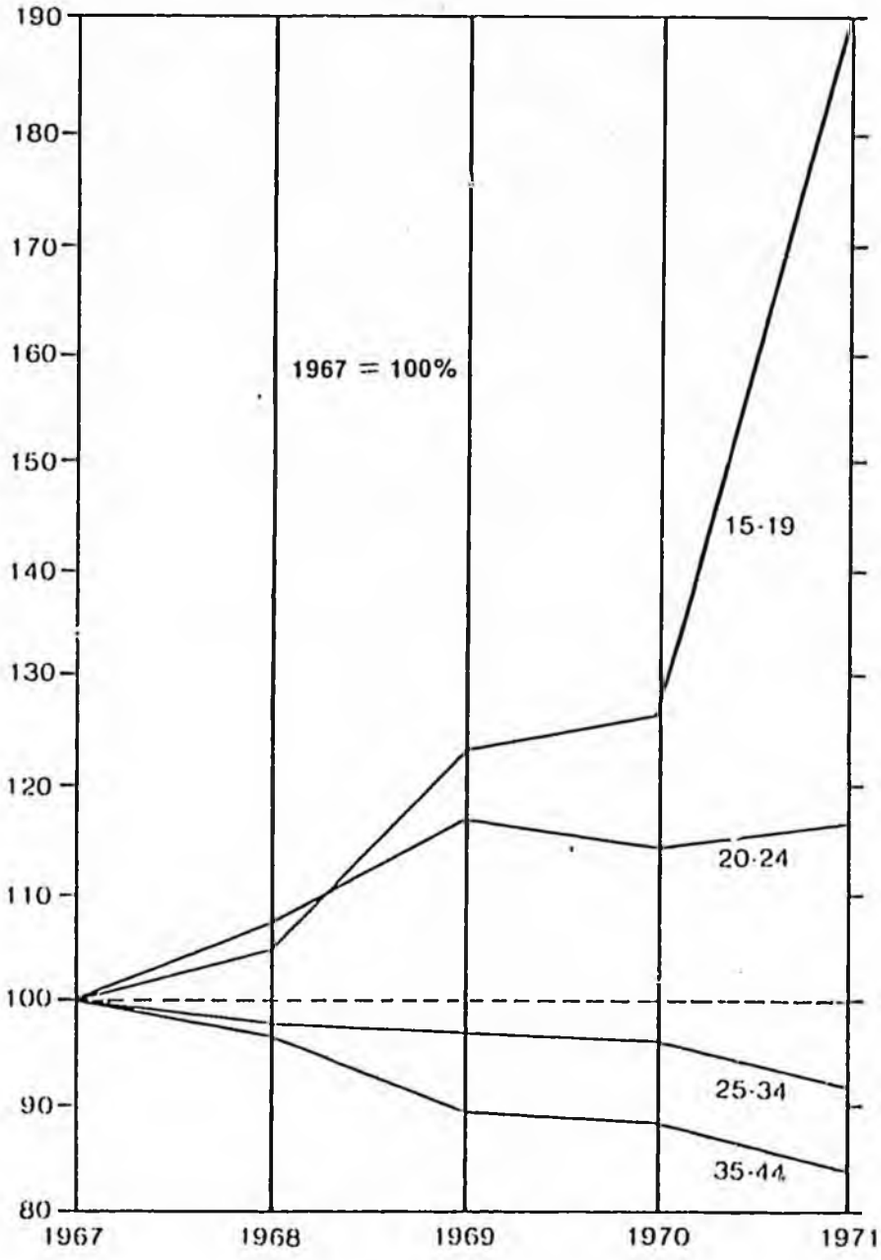
[a]A category including chiefly drinking under age, drinking in cars and other public places.

An important study by Whitehead (1977) was done in Ontario soon after the law was changed. This study examined records of male drivers in London, Ontario. After the reduction in the drinking age there was a 33% increase in alcohol-related accidents among 18-year-olds and a 34% increase among 19-year-olds. Increases were far lower among 24-year-olds (only 20%), who were not affected by the new law. There has been some debate about whether the changes would have occurred even without the law (e.g., Zylman 1974). However, this study was enlarged and extended in 1977 (Whitehead, 1977) and the final conclusion was that "the change in the law is associated with an increased rate of alcohol-related collisions among 18- to 20-year-old drivers and among 16- to 17-year-old drivers." It should be noted that alcohol-related accidents increased among 16- and 17-year-olds who were supposedly too young to be drinking. No doubt, lowering the age from 21 to 18 made it easier for them to drink.

Two studies in the United States have also examined changes after drinking age decreases. They are valuable because they include comparisons of states in which there has been no change. A study done at the Insurance Institute for Highway Safety (Williams et al., 1974) compared three states that had kept their drinking age at 21 (Indiana, Illinois, Minnesota) with Michigan, Wisconsin, and Ontario, which did not. This study showed that both single-vehicle fatal crashes and night-time crashes occurred more often in young people (under 21) after the law was changed. There was no comparable increase in areas that did not change the law. Unfortunately, this study also found increased accidents among those aged 15 to 18, who ought not to have been affected by the new law. This data suggests, as do other studies, that decreasing the drinking age probably allows increased access to alcohol by those who are younger than 18. The IIHS study showed that in the first year the new law probably lead to 29 excess deaths in Michigan, 28 in Ontario, and 13 in Wisconsin.

A similar study by Douglass and Filkins (1974) used data from Michigan, Vermont, and Maine, which lowered drinking ages. These states were compared with two that did not change (Pennsylvania and Texas). Increased accidents due to alcohol were found in Michigan and Maine but not Vermont. It may be that Vermont failed to change because it is relatively small and surrounded by areas with lower age laws. Recently this study

FIGURE 2 *Change in the Proportional Representation of Various Age Groups of Drinking Drivers in Accidents Ontario 1967–1971 1967 = 100%*



was extended and data up to 1976 was included (Flora, 1978). The conclusion was further supported that reducing the drinking age had cost lives in drinking accidents in Michigan.

The Reversal of Drinking Age Laws in Ontario and Elsewhere

In several areas of North America, public debate about the beneficial and harmful effects of the new age laws began shortly after their passage. The public in Ontario and elsewhere became aware of higher rates of alcohol-related accidents, and more drunkenness on the part of young people. School officials and teachers complained of students being able to drink at noon hour and return to school too intoxicated to learn. Certain types of school events, such as dances and football games, often became occasions for heavy drinking. There was also some awareness of increased absenteeism and disciplinary problems for high school students. On the positive side, it was argued that drinking was a natural civil right owed to all adults. The problems experienced might be only temporary and young people would eventually take responsibility for their own drinking. In general, young persons seemed in favor of a low drinking age and older persons did not.

The outcome of the debate in several areas was to partially reverse decisions to lower drinking age laws. In Saskatchewan it was decided to raise the drinking age to 19 again in 1976. Similar decisions were taken in Minnesota and Maine. Unfortunately, no studies have been made of the effects of raising the drinking age in Saskatchewan or Minnesota. Such studies take considerable time to do, particularly if they involve the use of such government records as traffic accident data, which may be as much as a year late in appearing.

In Ontario, the government raised the drinking age from 18 to 19 on December 31st, 1978. (It should be noted that in Ontario the age was not returned to 21, as it had been in 1971.) This change came as a result of several kinds of influence. Public opinion and debate as reflected in newspaper stories and the like seemed to favor a change--concern was often expressed in 1975 and 1976 about the large increase in youthful drinking and alcohol-related accidents. A study of public opinion done in 1976 in London, Ontario, indicated that almost 48% of adults were in favor of increasing the drinking age, most of them to

age 20 (Ennis et al., 1977). A larger study (Ogborne and Smart, 1978) done all over Ontario in 1977 indicated that 68% of adults wanted the drinking age set at 19 or above. Probably when the law was first changed in 1971 adults were mostly neutral or in favor of it but as experience with the law's effects increased, opinion shifted in a negative direction.

A significant event in the Ontario debate was the appointment of the Jones Commission, established by the government to elicit public reaction, examine the evidence, and recommend measures for dealing with youthful drinking problems. This commission conducted public meetings with both adults and youths across the province, and reviewed expert opinion from such government agencies as the Addiction Research Foundation and the Ministry of Health. The report of this commission made a large number of recommendations, including decreasing lifestyle alcohol advertisements, increasing educational efforts, making nonalcoholic beverages more available in bars, and increasing the drinking age to 19. The report became available in 1976. Another government committee was concerned with highway safety and it held deliberations in 1977. This was an all-party committee of the legislature termed "The Select Committee on Highway Safety." Although not concerned solely with youthful driving problems, this select committee recommended an increase in the drinking age to 19. The report became available in mid-1977.

The decision to reverse the age law was announced by the government in May of 1978 after a private member's bill had been sponsored by the opposition in the Ontario Legislature. It seemed to have broad public and political support and it was recommended by the Addiction Research Foundation as well as others such as home and teacher's associations and headmasters' groups.

At present, we cannot be positive whether the decision has substantially affected young people's drinking. It is a logical expectation that it should but empirical evidence is not available yet. It will probably have its greatest effect in combination with other measures, rather than solely on its own. Fortunately, the government raised the drinking age at the same time as it created new measures for better identification cards with the bearer's picture, provided higher penalties for serving alcohol to minors, severely restricted lifestyle advertisements, and improved alcohol education in schools. If the new alcohol control measures in Ontario have a major effect on drinking and driving problems among young people it will be difficult to decide exactly which measure has been most significant.

As of January 1, 1979, 19-year-olds and those who turned 18 in 1978 were allowed to drink in Ontario. As of January 1, 1980, all new drinkers had to be aged 19 or older and the last 18-year-olds became 19. The insertion of this "grandfather" clause into the law meant that its effects will not be felt for some time and that efforts to evaluate those effects will be delayed for several years.

Summary

The data relevant to the age change are consistent except for those for public drunkenness. Areas that lowered drinking ages have experienced far more drinking and alcohol-related traffic accidents than those that did not. In Toronto, however, drunkenness convictions did not increase after the new age law. No data are yet available from areas that raised drinking ages after initially lowering them, so it is still too early to judge the effects of this move. It seems most unlikely that any area would raise drinking ages to former levels. One problem, of course, is that the drinking age is frequently tied to age of majority. To change one without changing the other would likely be unpopular. It should be remembered, too, that persons 18 and over vote and form an important constituency. They might punish any government at the polls that decided to remove their rights piecemeal. Probably age changes ought to have been introduced more slowly (only beer) and in conjunction with a careful education campaign. In all provinces and most states, changes have already been made, but some areas can still benefit from the mistakes made by others. We know, too, that it is possible to change drinking age laws back to their earlier levels or at least to higher levels than 18. Public opinion in several areas seems to favor this more and logical arguments suggest it would be beneficial. Probably the greatest impact of such an increase would occur when combined with other measures such as penalties for serving underage drinkers and reductions in alcohol advertising.

Recently the age for drinking has been increased to 19 in Ontario. This change may have an important beneficial effect

by largely removing drinking from high schools. Also, it indicates that the government is serious about drinking problems among young people and intends to do something about them. Whether changing the age by only one year can have a large impact is debatable. Many studies will be needed to examine the effects of this change and they will take some time to complete as the law contains a "grandfather" clause.

The Effect of Raising the Legal Minimum Drinking Age on Fatal Crash Involvement

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The Effect of Raising the Legal Minimum Drinking Age on Fatal Crash Involvement

ABSTRACT

In the early 1970's, many states in the U.S. lowered their legal minimum drinking ages, resulting in increased fatal crash involvement among young drivers. Beginning in 1976 and continuing into the 1980's, some of these states raised their drinking ages. The present study, conducted in nine states in which the drinking ages were raised, found that this resulted in reductions in fatal crash involvement among drivers the law changes applied to, especially in types of fatal crashes in which alcohol is most often involved. The reductions in the nighttime fatal crash involvement of such drivers, that occurred in eight of the nine states, ranged from 6 to 75 percent. On average, a state that raises its drinking age can expect about a 28 percent reduction in nighttime fatal crash involvement among drivers the law change applies to. It was estimated that in the 14 states that had raised their drinking ages as of January 1981, the result each year is about 380 fewer young drivers involved in nighttime fatal crashes. In the 31 states that still had a legal minimum drinking age less than 21 as of that date, it is estimated that each year there could be about 730 fewer young drivers in nighttime fatal crashes if the legal drinking age were raised to 21.

In the early 1970's, more than half of the states in the U.S. lowered their legal minimum drinking ages -- in most cases from 21 to 18 -- for the purchase of some or all alcoholic beverages. Research indicated that this legislation resulted in increased crash involvement among young drivers.[1,2] In a study of various states and Canadian provinces that reduced their drinking ages from 21 to 18, there were significant increases in fatal crash involvement -- particularly in nighttime and single vehicle crashes in which alcohol is most often involved -- of drivers under 21 in these areas, compared with adjacent areas that did not reduce their drinking ages. These increases occurred not only among 18-20 year olds, who were directly affected by the law change, but also among 15-17 year olds.[1]

As a result of these findings and other reports of growing teenage alcohol-related problems, many states that had lowered their legal minimum drinking ages in the early 1970's raised them beginning in 1976. By the end of 1980, 14 of the 30 states that had lowered their drinking ages for the purchase of some or all alcoholic beverages had raised them, although not necessarily back to the original ages. In this paper, a study of the effect of raising the drinking age on fatal crash involvement of teenage drivers is reported.

METHODS

Research Design

Nine states, all of which raised their legal minimum drinking ages between September 1, 1976 and January 1, 1980, were studied. Four states that raised their drinking ages during 1980 were excluded, because the law changes were too recent for their effects to be measured using data available when the

study was conducted. New Jersey, which raised its drinking age from 18 to 19 on January 2, 1980, but included a "grandfather" clause permitting those already 18 before that date to drink, was also excluded.

Each of the nine states was paired with a comparison state in which the legal minimum drinking age remained unchanged during the study period. Comparison states were chosen on the basis of geographic proximity to law-change states and comparability with law-change states with respect to numbers of crash fatalities. Table 1 shows the law-change and comparison state pairs, and drinking age regulations in each state.

Table 1 goes here

Data on driver involvement in fatal crashes from January 1975 through September 1980 were obtained from the Fatal Accident Reporting System (FARS).* Only drivers of motor vehicles -- automobiles, light trucks, vans, on-off road vehicles -- were included.

Alcohol is a major factor in fatal motor vehicle crashes in general, but is particularly likely to be involved in nighttime fatal crashes (9:00 p.m. - 5:59 a.m.), especially single vehicle nighttime fatal crashes.[3-5] This subset of crashes therefore received special attention during the study.

The duration of post-law periods studied ranged from nine months (Illinois) to three years (Minnesota). In two states that raised their drinking ages from 18 to 19 but had a "grandfather" clause that permitted those already 18 years

* FARS is a computerized data base containing information on motor vehicle fatalities in the 50 states, the District of Columbia, and Puerto Rico. The data are collected by the state governments under contract to the National Highway Traffic Safety Administration. Police accident reports are the primary source of data, supplemented by data from medical examiners and other sources.

old to drink, the 12-month period following the law change dates was excluded. Pre-law and post-law periods for the nine states are shown in Figure 1. The ages to which the law changes apply are also given for each state in Figure 1.

Figure 1 goes here

Fatal crash involvement of drivers younger than those covered by the laws (starting with age 15) was also studied because of the possibility of spillover effects in these ages when alcoholic beverages could no longer be obtained legally by older teenagers. As a control, drivers older than those to whom the law changes applied (through age 21) who could drink legally in law change states throughout the study period were also included.

When a state changes its drinking age, there are possible effects on fatal crash involvement in adjacent states, both in the age groups the law changes apply to, and among their younger and older associates. These effects can be positive or negative. For example, if a state raises its drinking age from 18 to 21 and a neighboring state has an 18-year-old drinking age, then 18-20 year olds in the law-change state may travel to the neighboring state in order to drink legally, and may crash there. On the other hand, if a neighboring state has a 21 year old drinking age, 18-20 year olds in that state may no longer travel to the law-change state to drink, and consequently may crash less in both states.

These and other possible effects have a bearing on the research design used in the present study, which involved comparing law-change states with neighboring (although not necessarily contiguous) states, and also must be considered in assessing the net effect of states raising their legal minimum drinking age. It was found, however, that the number of drivers of the age

groups studied with out-of-state licenses in fatal crashes in law-change and comparison states in the pre- and post-law periods was small (less than 10 percent of the total). More importantly, the number of drivers in fatal crashes in law change states that were licensed in the comparison states (and fatal crash involved drivers in comparison states that were licensed in the law-change states) was less than one percent of the total.

Analyses based only on drivers licensed in the state in which the crash occurred produced the same results as analyses based on all drivers; the latter measure was therefore used.

Statistical Analysis

If raising the drinking age reduces driver involvement in alcohol-related fatal crashes, nighttime fatal crashes would be expected to be reduced more than daytime crashes (and single vehicle nighttime fatal crashes more than multiple vehicle daytime fatal crashes). In other words, the ratio of night-to-day fatal crashes in a law-change state would be greater before the law change than after it. This can be shown in a 2 x 2 table as follows:

	Time Period	
Time of Crash	Before Law Change	After Law Change
Night	n_{11}	n_{12}
Day	n_{21}	n_{22}

and $$\frac{n_{11}}{n_{21}} \geq \frac{n_{12}}{n_{22}} \qquad (1)$$

A statistical measure that compares such ratios is the log odds ratio,[6] defined as:

$$\beta = 2n \frac{n_{12}/n_{22}}{n_{11}/n_{21}} \qquad (2)$$

Positive values of β correspond to increases in the night/day ratio, negative values to decreases, and $\beta = 0$ whenever the ratio is unchanged. Except for small samples ($n \leq 5$) the distribution of β is asymptotically normal and its variance is approximately:

$$\sigma^2_\beta = \frac{1}{n_{11}} + \frac{1}{n_{12}} + \frac{1}{n_{21}} + \frac{1}{n_{22}} \qquad (3)$$

The hypothesis of no change in the night/day ratio subsequent to the law could therefore be tested in terms of the approximately standard normal test statistic $Z = \beta/\sigma_\beta$. Large negative values of Z would indicate a reduction in this ratio; large positive values an increase.

To rule out the possibility that changes in the ratios in law-change states were part of a regional trend, the log odds ratio for a law-change state (β_ℓ) was compared with the log odds ratio of the non-law change (comparison) state with which it was paired (β_c). To calculate β_c data for the comparison state were split into before and after periods that coincided with these periods in the law-change state. Positive, zero or negative values of the difference $\Delta\beta = \beta_\ell - \beta_c$ are indicative of greater, equal or smaller increases in the law-change state than in the comparison state. The variance of this test statistic is $\sigma^2_{\Delta\beta} = \sigma^2_{\beta_\ell} + \sigma^2_{\beta_c}$ and $\Delta\beta/\sigma_{\Delta\beta}$ is again standard normal if the change in the night/day ratio was the same in both states.

To rule out the possibility that changes observed in age groups covered by the law (and younger ages) were part of a trend in the night/day ratio that occurred in other age groups in law change states, log odds ratios in law-change and comparison states were compared for older drivers through age 21, to whom the law change did not apply. This was done by comparing $\Delta\beta_a$ for the law-affected group to a similarly calculated $\Delta\beta_o$ for the older age group. As before, the variance of $\Delta\beta_a - \Delta\beta_o$ is equal to $\sigma^2_{\Delta\beta_o} + \sigma^2_{\Delta\beta_a}$ and the test statistic is $(\Delta\beta_a - \Delta\beta_o)/(\sigma^2_{\Delta\beta_a} + \sigma^2_{\Delta\beta_o})^{\frac{1}{2}}$ which is standard normal in the absence of a difference between the $\Delta\beta$'s.

The log odds ratios were also used to estimate changes in the number and percentage of drivers in nighttime fatal crashes resulting from the law. Consider now the 2 x 2 x 2 contingency table for a given age group:

		State			
		Comparison		Law-Change	
		Before	After	Before	After
Time of Crash	Night	a	b		x
	Day	c	d	g	h

If the two odds ratios are the same then,

$$\frac{xg}{eh} = \frac{bc}{ad} = e^{\beta_c} \qquad \text{and } x = bceh/adg.$$

Now if, instead of x, the cell frequency is actually n, then the difference

$$\Delta n = n - x = n\,[1 - e^{\beta_c - \beta_\ell}] \qquad (4)$$

is the change in drivers involved in nighttime fatal crashes in the law-change state after the law went into force. This change can be expressed as a percentage:

$$\Delta P = 100\,\frac{\Delta n}{x} = 100\,[e^{\Delta\beta} - 1] \qquad (5)$$

Estimates of net changes in fatal crash involvement due to the laws were obtained by comparing the estimated changes for the age group covered by the law (ΔP_a) with the estimated change (ΔP_o) for the older group. Applying formula (5) for both age groups leads to the estimated net change due to the law for the law-affected group:

$$\Delta P_k = \frac{\text{Net change}}{\text{in state } k} = \frac{\Delta P_a - \Delta P_o}{1 + \Delta P_o} \qquad (6)$$

These methods were also used to determine what changes occurred in driver involvement in single vehicle nighttime fatal crashes and in all fatal crashes.

Data from the matched state pairs were analyzed by means of these methods in three different ways. The simplest analysis was based on data pooled across the nine law change and nine comparison states. In this analysis the pooled data were treated as if all of it had come from one change and one comparison state. This analysis disregards the variation between the states.

In the second method the "typical" change attributable to the laws was estimated as the average of the nine separate state estimates:

$$(\Delta P)_{av} = 1/9\ (\Delta P_1 + \ldots + \Delta P_9) \qquad (7)$$

The corresponding estimate for the variance of ΔP_k is

$$\sigma^2 = 1/8 \sum_{1}^{9} (\Delta P_k - (\Delta P)_{av})^2 \qquad (8)$$

and so the 95 percent confidence interval for the average is $(\Delta P)_{av} \pm 1.96\ \sigma/\sqrt{9}$. National projections for the estimated impact of already existing laws and the impact of further law changes were estimated on the basis of $(\Delta P)_{av}$.

Finally, to estimate the percentage change in driver fatal crash involvement that occurred in law-change states during the study period, the estimated changes were summed across the law-change states and divided by the estimated sum of the number of drivers that would have been in fatal crashes without the law change. This estimate corresponds to the "aggregate" change due to the laws. The aggregate change is a weighted average of the changes, whereas the typical change is an unweighted average. Statistical significance of the aggregate change was assessed in terms of the test statistic:

$$Z = \frac{1}{\sqrt{9}} \sum_{1}^{9} \frac{\Delta\beta_{ak} - \Delta\beta_{ok}}{(\sigma^2_{\Delta\beta_{ak}} + \sigma^2_{\Delta\beta_{ok}})^{1/2}} \qquad (9)$$

In the absence of a law effect Z would have a standard normal distribution.

RESULTS

Table 2 shows the results of comparisons between the nine law-change and comparison state pairs on driver involvement in fatal crashes before and after the laws went into force. In the age groups the laws applied to, there was a greater decrease in driver involvement in nighttime than in daytime fatal crashes in law-change states than in comparison states subsequent to the laws ($Z = -3.29$, $p = 0.001$). There was also a greater decrease in single vehicle nighttime fatal crash involvement than in multiple vehicle daytime fatal crash involvement for these ages ($Z = -2.85$, $p < 0.01$). There were an estimated 30 percent fewer drivers in the law-affected age groups in fatal nighttime crashes in law-change states during the post-law periods studied, and 41 percent fewer drivers in single vehicle nighttime fatal crashes. There was a decrease in driver involvement in all fatal crashes in law-change states in the age groups that the law applied to, but it was not statistically significant ($Z = -1.20$, $p > 0.10$).

Table 2 goes here

There was some indication of decreased fatal crash involvement of drivers in law-change states who were younger than drivers the law changes applied to, but the changes were not statistically significant. This was also the case when comparisons were based only on drivers one year younger. There were also small, non-significant changes for older drivers in law-change states.

The three sets of estimates of the percent net reductions in fatal crash involvement of drivers in law-change states to whom the law changes applied are given in Table 3. The three estimation methods yielded reasonably consistent results. Estimated reductions in driver involvement in nighttime fatal crashes

ranged from 18 to 28 percent; all three estimates were statistically significant. Estimated reductions in driver involvement in single vehicle nighttime crashes ranged from 23 to 35 percent. Although these reductions were higher than the nighttime reductions, only the aggregate estimate was statistically significant, in part because of the smaller number of drivers in nighttime single vehicle crashes. There were smaller estimated reductions in all fatal crashes (12 to 20 percent); the pooled estimate was statistically significant.

Table 3 goes here

Table 4 shows, for each of the nine law-change states, the estimated post-law changes in nighttime fatal crash involvement for law-affected and older drivers, and the net effects. The net effects of the laws on drivers the law changes applied to are also displayed in Figure 2. There were estimated net reductions in driver involvement in nighttime fatal crashes in eight of the nine states, ranging from 6 to 75 percent. Montana was the lone state in which there was not a net reduction. The average reduction in the nine states was 28 percent (± 17 percent for a 95 percent confidence interval).

Table 4 goes here

Figure 2 goes here

Figure 3 displays the estimated effects of driver involvement in nighttime fatal crashes as deseasonalized monthly time series from 1975 into 1980 as the

nine states studied raised their legal minimum drinking ages.*

Figure 3 goes here

DISCUSSION

When states lowered their legal minimum drinking ages in the early 1970's, the result was an increase, among both law-affected and younger drivers, in involvement in fatal crashes, especially those crashes in which alcohol is most often involved. The results of the present study indicate that when states raise their drinking age, there is a corresponding decrease in fatal crash involvement among law-affected drivers. There is some evidence that raising the drinking age also affects younger drivers, but the reductions in the involvement of younger drivers in fatal crashes were not statistically significant.

For the 14 states (including the nine studied plus five others) that as of January 1981 had raised their legal minimum drinking ages in recent years, it is estimated that these law changes result each year in about 380 fewer young drivers involved in nighttime fatal crashes.** For the 31 states (including seven of the nine studied) that as of January 1981 had a drinking age for

* The estimated monthly series was obtained in three steps. First, for each month the data in the 2 x 2 table representing day/night and law change/no law change splits were pooled among states that had already raised the drinking age, and the frequency of nighttime crash involvement in the change state was estimated so that the odds ratio of the modified table then equalled the odds ratio for a similar table obtained by pooling all pre-law change counts across all months and all states. Second, these estimated counts for the post-law periods in the change states were added to the sum of the observed counts in the states that still did not change their laws. Third, this sum was smoothed using X-11. The estimated monthly reduction in fatal crash involvement was subdivided between law effect and other factors using a constant factor (40 percent). This factor represents the estimated reduction in the involvement of older drivers.

** This annual estimate was based on data from 1979, the last full year for which FARS data were available when the presen study was conducted.

some or all alcoholic beverages that was less than 21,* it is estimated that each year there could be about 730 fewer young drivers involved in nighttime fatal crashes if in all states the drinking age for all alcoholic beverages was raised to 21. Any single state that raises its drinking age can expect the involvement in nighttime fatal crashes of drivers of the age groups to which the change in the law applies to drop by about 28 percent.

The societal benefits achieved in states that have raised their drinking ages are substantial; the benefits achievable by additional states raising their drinking ages would be even more substantial. Raising the legal minimum drinking age to 21 in all states would have an important impact in reducing the annual toll of motor vehicle deaths in the United States, particularly the deaths of young people and of others with whom they are involved in crashes.

* If persons less than age 21 were allowed to purchase only beer containing not more than 3.2% alcohol by weight,. the state was classified as having a 21-year-old drinking age.

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TABLE 1

Legal Minimum Drinking Ages in Law-Change and Comparison States[1]

Law-Change State	Drinking Age Change From	To	Effective Date	Comparison State	Legal Minimum Drinking Age
Illinois[2]	19	21	1/1/80	Indiana	21
Iowa[3]	18	19	7/1/78	Kansas[4]	21
Maine	18	20	10/24/77	Vermont	18
Massachusetts	18	20	4/1/79	Connecticut	18
Michigan	18	21	12/23/78	Ohio[4]	21
Minnesota[3]	18	19	9/1/76	Wisconsin	18
Montana	18	19	1/1/79	Idaho	19
New Hampshire	18	20	5/24/79	Part of New York[5]	18
Tennessee	18	19	6/1/79	Kentucky	21

1 The laws apply to all alcoholic beverages except where noted.

2 The age change applied to beer and wine; the legal minimum drinking age for distilled spirits was 21 throughout the study period. Prior to the 1980 change, home rule units in Illinois had the authority to promulgate different laws for drinking ages. Some raised the drinking age from 19 to 21 for beer and wine before the statewide change in 1980, although in some cases, beer and wine purchase by 19-20 year olds was permitted under some conditions.

3 A "grandfather" clause permitted 18 year olds to drink if they were 18 before the law went into effect.

4 The legal minimum drinking age was 18 for beer with not over 3.2% alcohol content, and 21 for other alcoholic beverages.

5 The following counties in central and northern New York were included: Clinton, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Oswego, St. Lawrence, Saratoga, Warren, and Washington.

TABLE 2

Statistical Tests Comparing Changes in Driver Involvement in Fatal Crashes Before and After Changes in Legal Minimum Drinking Ages

Fatal Crash Ratios Compared	Driver Categories: Drivers the Law Change Applied to		Younger Drivers		Older Drivers	
	Z statistic[1]	Estimated change(%)	Z statistic[1]	Estimated change(%)	Z statistic[1]	Estimated change(%)
Nighttime : Daytime	-3.29**	-30	-0.29	-6	-0.53	-15
Single Vehicle Nighttime : Multiple Vehicle Daytime	-2.85*	-41	-0.32	-12	-0.20	-9
All Types	-1.20	-11	-0.91	-7	+1.03	+11

[1] Z is standard normal under the null hypothesis. See text.

** $p = 0.001$, two-tailed

* $p < 0.01$, two-tailed

TABLE 3

Estimated Percent Net Reductions in Fatal Crash Involvement of Drivers to Whom Changes in the Legal Minimum Drinking Ages Applied

Fatal Crash Type	Method of Estimation[1]		
	Aggregate	Typical	Pooled
Nighttime	-18%*	-28%**	-23%*
Single vehicle nighttime	-35%*	-23%	-25%
All types	-20%	-12%	-14%*

[1] See text.

** $p < 0.001$, two-tailed

* $p < 0.05$, two tailed

TABLE 4

Estimated Changes in Nighttime Fatal Crash Involvement After Changes in the Legal Minimum Drinking Ages in Nine States, and Net Reductions in the Age Group the Law Change Applied To

Law-Change State	Change in Nighttime Fatal Crash Involvement		Net Reduction Among Drivers the Law Change Applied to
	Drivers the Law Change Applied to	Older Drivers	
Illinois	-30%	-9%	-23%
Iowa	-60%	-29%	-45%
Maine	-14%	-3%	-11%
Massachusetts	-10%	-5%	-6%
Michigan	-17%	+40%	-41%
Minnesota	-56%	-32%	-34%
Montana	+17%	+3%	+14%
New Hampshire	-55%	+80%	-75%
Tennessee	-43%	-14%	-33%
Average Reduction			-28%*

* ± 17% for a 95% confidence interval.

FIGURE 1

PRE-LAW AND POST-LAW PERIODS STUDIED, AND AGES THE LAW CHANGES APPLY TO

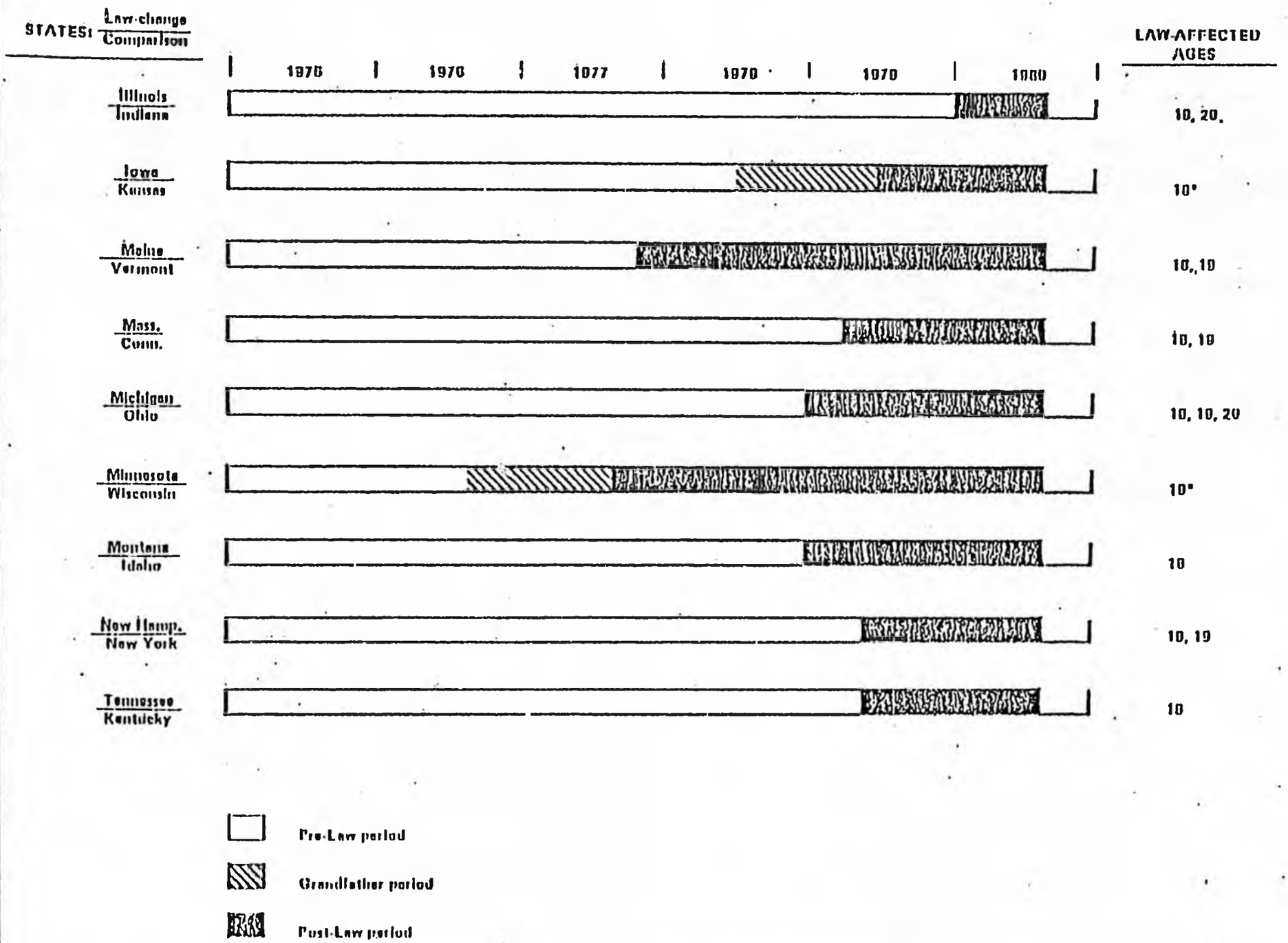


FIGURE 2

NET CHANGES IN DRIVER INVOLVEMENT IN NIGHTTIME FATAL CRASHES AFTER CHANGES IN THE LEGAL MINIMUM DRINKING AGES

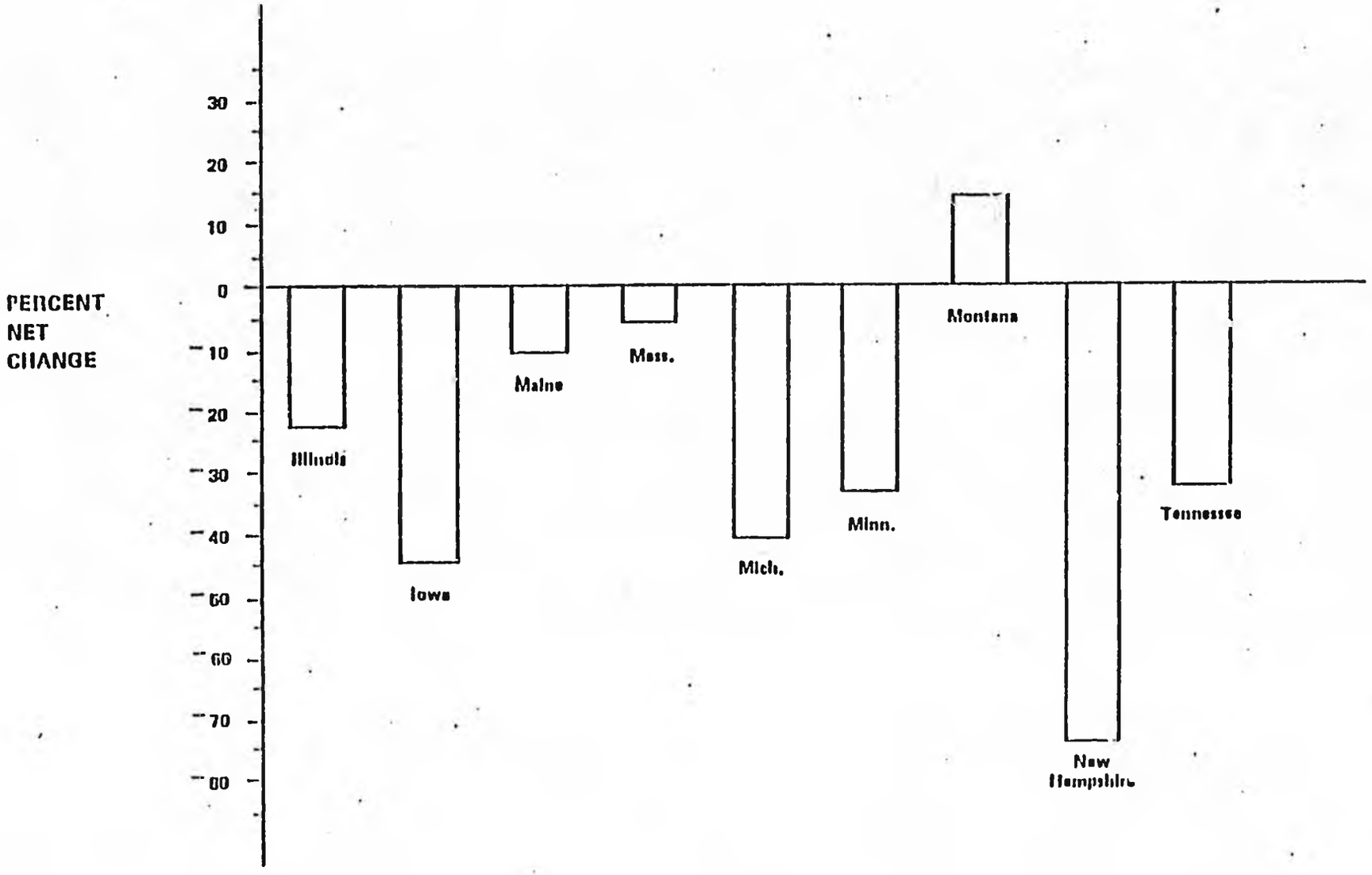
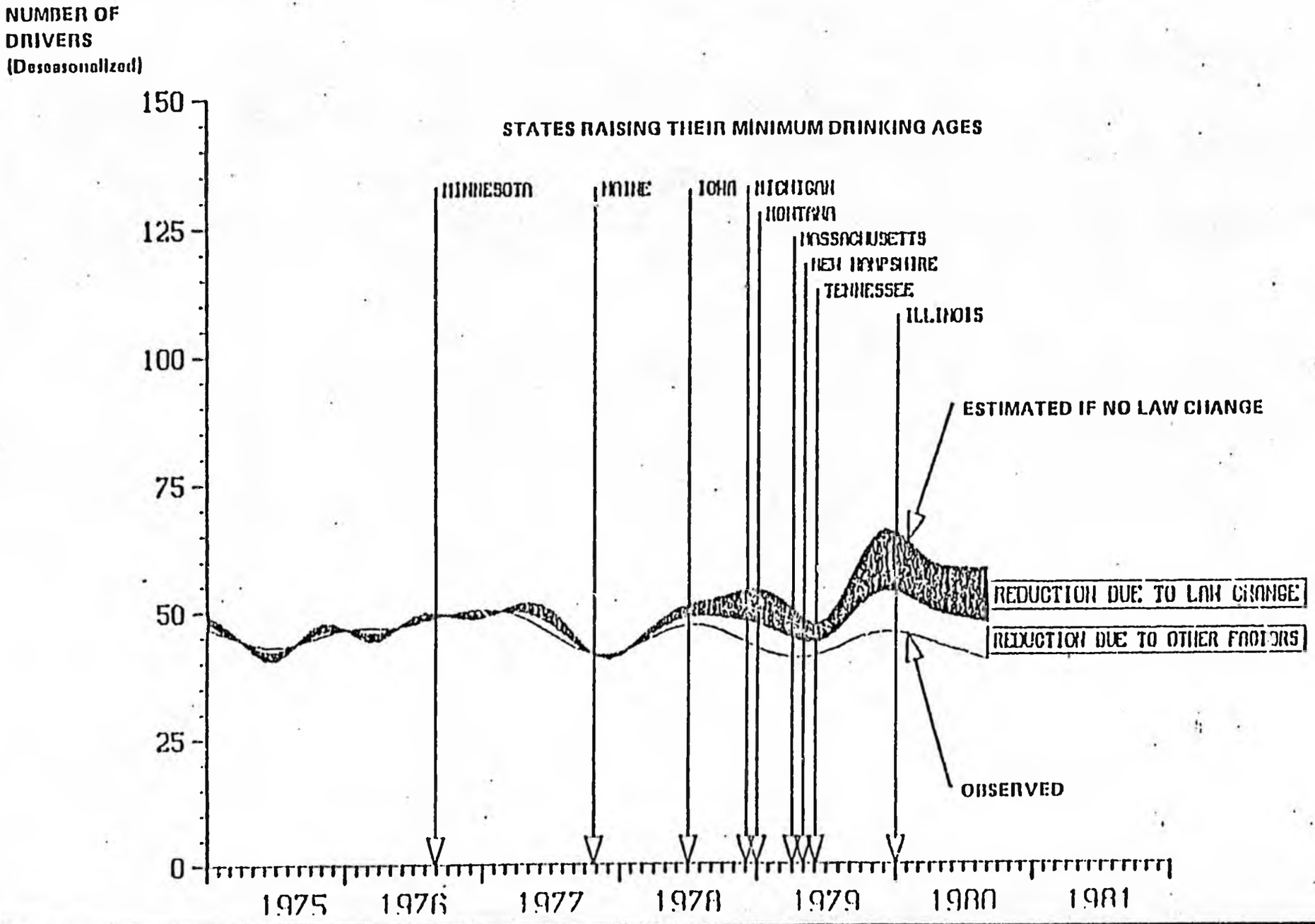


FIGURE 3

ESTIMATED NET REDUCTION IN NIGHTTIME FATAL CRASH INVOLVEMENT
IN NINE STATES THAT RAISED THEIR LEGAL MINIMUM DRINKING AGES



Introduced: 1/17/83
Referred: Judiciary

BY MARTIN, M.W.MILLER, M.M.MILLER, VASKA AND LINDAUER

IN THE HOUSE

HOUSE BILL NO. 17

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to age limits under Title 4, Alcoholic Beverages."

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

* Section 1. AS 04.11.090(f) is amended to read:

(f) The area designated as the licensed premises under a beverage dispensary license issued to a bowling alley may include the concourse or lane areas of the bowling alley. Notwithstanding AS 04.16.049, the board may, upon application, authorize access by persons under 21 [19] years of age to the concourse or lane areas designated part of the bowling alley's licensed premises during hours when no alcoholic beverages are being sold, served, or consumed.

* Sec. 2. AS 04.11.110(g) is amended to read:

(g) Notwithstanding AS 04.16.049, the board may authorize access by persons under 21 [19] years of age to a club's licensed premises during hours when no alcoholic beverages are sold, served, or consumed.

* Sec. 3. AS 04.11.460(c) is amended to read:

(c) For the purposes of this section, "permanent resident" means a person 21 [19] years of age or older who has established a permanent place of abode.

* Sec. 4. AS 04.16.049 is amended to read:

Sec. 04.16.049. ACCESS OF PERSONS UNDER THE AGE OF 21 [19] TO LICENSED PREMISES. (a) A person under the age of 21 [19] years may not knowingly enter or remain in premises licensed under this title

unless

(1) accompanied by a parent, guardian or spouse who has attained the age of 21 [19] years;

(2) accompanied by a person over the age of 21 [19] years and with the consent of the person's parent or guardian if the premises are designated by the board as a restaurant for the purposes of this section and the persons enter and remain only for dining.

(b) Notwithstanding (a) of this section, a licensee or an [, HIS] agent [,] or employee of the licensee may refuse entry to a person under the age of 21 [19] years to that part of licensed premises in which alcoholic beverages are sold, served, or consumed, may refuse service to a person under the age of 21 [19] years, or may require a person under the age of 21 [19] years to leave the portion of the licensed premises in which alcoholic beverages are sold, served, or consumed.

(c) Notwithstanding this section, a person between 16 and 21 [19] years of age may enter and remain within the licensed premises of a hotel, restaurant, or eating place in the course of [HIS] employment if (1) the employment does not involve the serving, mixing, delivering, or dispensing of alcoholic beverages; (2) the person has the written consent of a parent or guardian; and (3) an exemption from the prohibition of AS 23.10.355 is granted by the Department of Labor. The board, with the approval of the governing body having jurisdiction and at the licensee's request, shall designate which premises are hotels, restaurants, or eating places for the purposes of this subsection.

* Sec. 5. AS 04.16.050 is amended to read:

Sec. 04.16.050. POSSESSION OR CONSUMPTION BY PERSONS UNDER THE AGE OF 21 [19]. A person under the age of 21 [19] years may not

knowingly consume, possess, or control alcoholic beverages except those furnished persons under AS 04.16.051(b).

* Sec. 6. AS 04.16.051(a) is amended to read:

Sec. 04.16.051. FURNISHING OF ALCOHOLIC BEVERAGES TO PERSONS UNDER THE AGE OF 21 [19]. (a) A person may not furnish an alcoholic beverage to a person under the age of 21 [19] years.

* Sec. 7. AS 04.16.052 is amended to read:

Sec. 04.16.052. FURNISHING OF ALCOHOLIC BEVERAGES TO PERSONS UNDER THE AGE OF 21 [19] BY LICENSEES. A licensee or an [, HIS] agent [,] or employee of the licensee may not with criminal negligence

(1) allow another person to sell, barter, or give an alcoholic beverage to a person under the age of 21 [19] years within licensed premises;

(2) allow a person under the age of 21 [19] years to enter and remain within licensed premises except as provided in AS 04.16.-049;

(3) allow a person under the age of 21 [19] years to consume an alcoholic beverage within licensed premises;

(4) allow a person under the age of 21 [19] years to sell or serve alcoholic beverages.

* Sec. 8. AS 04.16.060 is amended to read:

Sec. 04.16.060. PURCHASE BY PERSONS UNDER THE AGE OF 21 [19]. (a) A person under the age of 21 [19] years may not purchase alcoholic beverages or solicit another to purchase alcoholic beverages for the person under the age of 21 [ON HIS BEHALF].

(b) A person may not influence the sale, gift, or service of an alcoholic beverage to a person under the age of 21 [19] years, by misrepresenting the age of that person.

(c) A person may not order or receive an alcoholic beverage from

a licensee, an [HIS] agent or [,] employee of the licensee, or another person, for the purpose of selling, giving, or serving it to a person under the age of 21 [19] years.

(d) A person under the age of 21 [19] years may not enter licensed premises where alcoholic beverages are sold and offer or present to a licensee or an [, HIS] agent [,] or employee of the licensee a birth certificate or other written evidence of age, that [WHICH] is fraudulent or false or that [WHICH] is not actually the person's [HIS] own, or otherwise misrepresent the person's [HIS] age, for the purpose of inducing the licensee or an [, HIS] agent [,] or employee of the licensee to sell, give, serve, or furnish alcoholic beverages contrary to law.

(e) A person who has attained the age of 21 [19] years accompanying a person under the age of 21 [19] who is seeking to enter and remain in a licensed premises under AS 04.16.049(a)(2) may not misrepresent having obtained the consent of the parent or guardian of the person under the age of 21 [19] years.

* Sec. 9. AS 04.16.200(b)(2) is amended to read:

(2) the sale or offer for sale was made to a person under 21 [19] years of age; or

* Sec. 10. AS 04.16.200(c) is amended to read:

(c) It is an affirmative defense to a prosecution under (a) of this section that no profit was involved in the solicitation or receipt of an order for the delivery of an alcoholic beverage. However, the affirmative defense created under this subsection is not available in a prosecution of a person charged with selling or offering for sale alcoholic beverages to a person under 21 [19] years of age.

* Sec. 11. AS 04.21.020(1) is amended to read:

(1) the alcoholic beverages are provided to a person under

the age of 21 [19] years in violation of AS 04.16.051, unless the licensee, agent, or employee secures in good faith from the person a signed statement, liquor identification card, or drivers' license meeting the requirements of AS 04.21.050(a) and 04.21.050(b), that [WHICH] indicates that the person is 21 [19] years of age or older; or

* Sec. 12. AS 04.21.050(a) is amended to read:

(a) If a licensee [,] or an agent or employee of the licensee questions or has reason to question whether a person entering [A] licensed premises, or ordering, purchasing, attempting to purchase, or otherwise procuring or attempting to procure alcoholic beverages, has attained the age of 21 [19] years, that licensee, agent, or employee shall require the person to furnish proof of age acceptable under (b) of this section. If the person questioned does not furnish proof of age acceptable under (b) of this section, or if a licensee, agent, or employee questions or has reason to question the validity of the proof of age furnished, the licensee, employee, or agent shall require the person to sign a statement that the person [HE] is over the age of 21 [19] years. This statement shall be made on a form prepared by and furnished to the licensee by the board.

* Sec. 13. AS 04.21.050(c) is amended to read:

(c) A licensee, or an agent or employee of the licensee, may not be charged for a violation of AS 04.16.051 - 04.16.052 if a signed statement as provided in (a) of this section is secured in good faith, or a valid driver's license or identification card is presented indicating that the owner and possessor of the presented driver's license or identification card is 21 [19] years of age or over.

* Sec. 14. AS 23.10.355 is amended to read:

Sec. 23.10.355. PERSONS UNDER 21 [19]. No person under 21 [19] may be employed or allowed to sell or serve alcoholic beverages or to

work in any room or other place where alcoholic beverages are sold for consumption on the premises, except as provided in AS 04.16.049(c).

COMMITTEE REPORT

HOUSE

(11) FURTHER:

3/4/83

Date: 4-18-83

Mr. Speaker:

The Committee on FINANCE has had SSBB 19

An Act repealing the certificate of need program; and providing for an effective date.

under consideration and reports it back as follows:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[X] replace with CS for SSHB 19 (Fin) [ ] same title [X] new title

and recommends DO RECOMMENDATION

[ ] AND attaches a "Letter of Intent" [X] New Fiscal Note

[X] Zero Fiscal Note Attached

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING
DO PASS

MEMBERS HAVING
OTHER RECOMMENDATIONS:

CHAIRMAN

H 60

Original sponsors: Fritz, Hayes,
Zharoff, et al

IN THE HOUSE BY THE FINANCE COMMITTEE

CS FOR SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 19 (Finance)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to the certificate of need program, state aid for health facilities, Medicaid, and general relief medical assistance; and providing for an effective date."

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

* Section 1. AS 18.07.021 is amended to read:

Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY. The division of planning, policy, and program evaluation [OFFICE OF PLANNING AND RESEARCH] in the department is the state health planning and development agency designated under 42 U.S.C. Sec. 300m(b)(3), (Sec. 3, P.L. 93-641) [SEC. 1521(b)(3), P.L. 93-641]. The division [OFFICE] shall perform the functions enumerated under 42 U.S.C. Sec. 300m-2, (Sec. 3, P.L. 93-641) and [SEC. 1523,P.L. 93-641,] administer the certificate of need program [OUTLINED IN AS 18.07.041 - 18.07.111,] and other functions prescribed in this chapter.

* Sec. 2. AS 18.07.021 is amended to read:

Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY. The division of planning, policy, and program evaluation in the department is the state health planning and development agency designated under 42 U.S.C. Sec. 300m(b)(3), (Sec. 3, P.L. 93-641). The division shall perform the functions enumerated under 42 U.S.C. Sec. 300m-2(a)(1)-(3), (a)(5)-(8), (b) and (c) [42 U.S.C. SEC. 300m-2], (Sec. 3, P.L. 93-641), [AND ADMINISTER THE CERTIFICATE OF NEED PROGRAM] and other functions prescribed in this chapter.

* Sec. 3. AS 18.07.031 is repealed and reenacted to read:

Sec. 18.07.031. CERTIFICATE OF NEED REQUIRED. (a) A person may not undertake the following unless authorized under the terms of a certificate of need issued by the division:

(1) construction of a health care facility at a cost of $1,000,000 or more;

(2) alteration of the bed capacity of a health care facility;

(3) addition or elimination of a category of health services provided by a health care facility;

(4) expenditure of $1,000,000 or more for diagnostic medical equipment to be used in a health facility.

(b) The requirement of (a)(4) of this section does not apply to expenditures for replacement equipment with the same or a similar capability as the equipment replaced.

(c) The legislature may not appropriate, nor may a person receive, state money for construction that requires a certificate of need or for a purchase of equipment that requires a certificate of need unless the certificate has been issued or modified under this chapter.

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

Sec. 18.07.033. REVIEW OF APPLICATIONS FOR CERTIFICATE OF NEED. (a) The division, and then the commissioner, shall review applications for certificates of need. The division and the commissioner may consult with a health systems agency or a municipal health commission concerning an application for a certificate of need. Approval of an application for a certificate of need may not be conditioned on approval of the application by a health systems agency or a municipal health commission.

(b) Not later than 90 days after an applicant has submitted a completed application for issuance or modification of a certificate of need, the application shall be reviewed by the commissioner and granted or denied.

* Sec. 5. AS 18.07.041 is amended to read:

Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES OF NEED. The division [OFFICE] shall issue [GRANT] a sponsor a certificate of need or modify a certificate of need if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of Alaska citizens.

* Sec. 6. AS 18.07.061 is amended to read:

Sec. 18.07.061. MODIFICATION AND TERMINATION OF ACTIVITIES. The certificate holder shall apply to the division [OFFICE] for a modification of the certificate before terminating part of the activities authorized by the terms of issuance, but the certificate holder is not required to obtain the acquiescence of the division [OFFICE] before terminating all the activities authorized by the certificate. If a certificate holder terminates all of the activities authorized by a certificate, the certificate holder is required to notify the division [OFFICE] 60 days before termination and to surrender the certificate to the division [OFFICE] within 30 days of termination.

* Sec. 7. AS 18.07.071 is amended to read:

Sec. 18.07.071. TEMPORARY AND EMERGENCY CERTIFICATES. (a) The division [OFFICE] shall grant a sponsor an emergency certificate for the construction of a health care facility for which a certificate is required under AS 18.07.031 if the sponsor shows, by affidavit or formal hearing, that the act of construction consists of effecting

emergency repairs.

(b) The division [OFFICE] may grant a sponsor a temporary certificate for the temporary operation of a category of health service, if the sponsor shows by affidavit or formal hearing

(1) the necessity for early, immediate, or temporary relief, and

(2) adverse effect to the public interest by reason of delay occasioned by compliance with the requirements of AS 18.07.041 and application procedures prescribed by regulations under this chapter.

(c) A temporary certificate granted under (b) of this section confers no vested rights on behalf of the applicant. The division [OFFICE] shall impose those special limitations and restrictions concerning duration and right of extension which the division [OFFICE] considers appropriate. No temporary certificate may be granted for a period longer than necessary for the sponsor to obtain review of the action certified by the temporary certificate under AS 18.07.051. Application for a certificate of need under AS 18.07.041 must commence within 60 days of the date of issuance of the temporary certificate.

* Sec. 8. AS 18.07.081(a) is amended to read:

(a) The division [OFFICE], a member of the public who is substantially affected by activities authorized by the certificate, or another applicant for a certificate of need may initiate a hearing to obtain modification, suspension or revocation of an existing certificate of need by filing an accusation with the commissioner as prescribed under AS 44.62.360. No revocation, modification, or suspension of an outstanding certificate may be undertaken unless it is in accordance with AS 44.62.330 - 44.62.630.

* Sec. 9. AS 18.07.081(c) is amended to read:

(c) A certificate of need shall be suspended if an accusation is filed before the commencement of activities authorized under AS 18.07.041 which charges that factors upon which the certificate of need was issued have changed, or new factors have been discovered which significantly alter the need for the activity authorized. A suspension of a certificate may not exceed 60 days. At the end of this period or sooner, the <u>division</u> [OFFICE] shall revoke or reinstate the certificate.

* Sec. 10. AS 18.07.101 is amended to read:

Sec. 18.07.101. REGULATIONS. The commissioner shall adopt, in accordance with the Administrative Procedure Act (AS 44.62), regulations which establish procedures under which sponsors may make application for certificates of need required by this chapter and which govern the review of those applications by the <u>division</u> [OFFICE], establish requirements for a uniform statewide system of reporting financial and other operating data, and otherwise carry out the purposes of this chapter.

* Sec. 11. AS 18.07.111 is amended by adding a new paragraph to read:

(13) "division" means the division of planning, policy, and program evaluation in the Department of Health and Social Services.

* Sec. 12. AS 18.26.220 is repealed and reenacted to read:

Sec. 18.26.220. FACILITY COMPLIANCE WITH HEALTH AND SAFETY LAWS AND LICENSING REQUIREMENTS. In order to receive financial assistance under this chapter, a medical facility shall comply with AS 18.20 and the licensing requirements of this chapter.

* Sec. 13. AS 29.89.030(a)(1) is repealed and reenacted to read:

(1) to a municipality that has the power to provide hospital facilities and services and that exercises that power, $250,000 per hospital for those hospitals with 10 or more acute care beds, and

$50,000 per hospital for those hospitals with less than 10 acute care beds; money received under this paragraph may be used only for hospitals and shall be apportioned among qualifying hospitals as the municipality determines;

* Sec. 14. AS 47.07.070 is repealed and reenacted to read:

Sec. 47.07.070. PAYMENT TO HEALTH FACILITIES. (a) The commission shall determine prospectively the rate of payment to a health facility under this chapter and AS 47.25.120 - 47.25.300 based on a fair rate for reasonable costs incurred by the facility. The commission shall by regulation list the factors it considers in making its rate determinations under this section.

(b) In determining a rate of payment to a health facility under this section, the commission shall consider the proportionate share of the facility's financial requirements for patient care for

(1) costs of current operations, including salaries and wages; purchased services, supplies, insurance, leases, depreciation, taxes, interest expense, maintenance and other health facility operating expenses; and

(2) education, research, and appropriate capital development.

(c) In determining a rate of payment to a health facility under this section, the commission may consider whether the rate of utilization of the facility has been reduced because of improvement or careless development of the facility.

* Sec. 15. AS 47.07 is amended by adding new sections to read:

Sec. 47.07.071. REPORTS BY HEALTH FACILITIES. Not later than 120 days after the end of each fiscal year of a health facility, the facility shall submit to the commission a report on the facility's financial performance during the fiscal year.

Sec. 47.07.072. REPORT BY THE COMMISSION. Not later than September 30 of each year, the commission shall submit to the governor a report on the prospective payments made under this chapter during the current fiscal year and an estimate of the prospective payments that will be made during the remainder of the current fiscal year and the next fiscal year. The report shall state the assumptions that are used as a basis for the estimates.

Sec. 47.07.073. UNIFORM ACCOUNTING, BUDGETING, AND FINANCIAL REPORTING. (a) The commission by regulation shall require a uniform system of accounting, budgeting, and financial reporting for health facilities receiving prospective payments under this chapter. The regulations shall provide for the reporting of revenues, expenses, assets, liabilities, and units of service. The commission shall specify the date the system becomes effective for each health facility.

(b) In adopting regulations under this section, the commission shall consider

(1) accounting, budgeting, and financial reporting procedures used by health facilities;

(2) variations among health facilities in the types of health care services provided by health facilities;

(3) other factors the commission considers relevant, including the size and organizational structure of health facilities and the methods used by health facilities to obtain payments.

(c) The commission may waive or modify a requirement for accounting, budgeting, or financial reporting for a health facility if waiver or modification is

(1) necessary to avoid excessive costs to the facility; and

(2) consistent with the policies of this chapter.

(d) Notwithstanding other provisions of this section, the commission may, by regulation, modify the system of accounting, budgeting, and financial reporting required under this section for a health facility having less than 25 acute care beds in order to reduce the operating costs of that facility.

Sec. 47.07.074. AUDITS AND INSPECTIONS. As a condition of obtaining payment under AS 47.07.070, a health facility shall allow

(1) the department and the commission reasonable access to the financial records of medical assistance beneficiaries; and

(2) inspection of financial records by state and federal agencies to the extent required by federal law.

Sec. 47.07.075. APPLICATION OF ADMINISTRATIVE PROCEDURE ACT. Actions of the commission under AS 47.07 and AS 47.25.120 - 47.25.300 are subject to the provisions of the Administrative Procedure Act (AS 44.62).

* Sec. 16. AS 47.07.080 is amended by adding new paragraphs to read:

(6) "commission" means the Medicaid Rate Commission;

(7) "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic.

* Sec. 17. AS 47.07 is amended by adding new sections to read:

ARTICLE 2. MEDICAID RATE COMMISSION.

Sec. 47.07.110. MEDICAID RATE COMMISSION ESTABLISHED. The Medicaid Rate Commission is established in the Department of Health and Social Services.

Sec. 47.07.120. COMPOSITION OF COMMISSION. The commission consists of five members as follows:

(1) the chief executive officer of a health facility that is licensed by the state but not owned or operated by the state or federal government and that is subject to the budget review process under this chapter;

(2) the commissioner of administration, the commissioner of health and social services, or the appointed designee of either commissioner;

(3) a physician licensed to practice medicine in the state who is actively engaged in the practice of medicine and who is not employed by the state;

(4) a certified public accountant with relevant experience;

(5) a person representing consumers of health services who does not have a direct or indirect interest in an entity that provides health care services.

Sec. 47.07.130. APPOINTMENT OF MEMBERS. Members of the commission are appointed by the governor and serve at the pleasure of the governor.

Sec. 47.07.140. TERM OF MEMBERSHIP. The term of a member of the commission appointed under AS 47.07.120(1), (3), (4), or (5) is three years. A member may not be appointed to a successive term. The terms of the members shall be staggered. A member appointed to fill a vacancy serves for the unexpired term of the member. A term shall be measured from January 1 of the year in which the term of the vacant position begins, regardless of when the vacancy is filled.

Sec. 47.07.150. COMPENSATION. A member of the commission serves without compensation but is entitled to per diem and travel expenses authorized by law for boards and commissions under AS 39.20.180.

Sec. 47.07.160. OFFICERS. At the first meeting of each year, the commission shall elect a chair from among its members.

Sec. 47.07.170. MEETINGS AND QUORUM. The commission shall meet as often as is necessary to conduct its business. Three members of the commission constitute a quorum.

Sec. 47.07.180. DUTIES. The commission shall review proposed payment rates and budgets of health facilities and establish payment rates for health facilities under this chapter and AS 47.25.120 - 47.25.300.

Sec. 47.07.190. EMPLOYMENT OF PERSONNEL. The commission may employ and determine the salary of an executive director. With the approval of the commission, the executive director may select and employ additional staff. The commission shall be assisted by the officers or personnel of the department as the commissioner of health and social services shall direct. The executive director of the commission is in the exempt service under AS 39.25.

* Sec. 18. AS 47.25 is amended by adding a new section to read:

Sec. 47.25.195. PAYMENT TO HEALTH FACILITIES FOR TREATMENT OF NEEDY PERSONS. (a) The department may make payments to a health facility for the treatment of a needy person.

(b) A health facility receiving a payment under this chapter is subject to the requirements of AS 47.07.070 - 47.07.075.

(c) For purposes of this section, "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic.

* Sec. 19. INTERIM PROSPECTIVE PAYMENT SYSTEM. The department shall establish an interim system of prospective payments for health facilities under this Act for the period July 1, 1983 to June 30, 1984.

* Sec. 20. During the second regular session of the Fourteenth Alaska

State Legislature, and every third regular session thereafter, the legislature shall review the certificate of need program (AS 18.07.031 - 18.07.111) and the state aid for hospital and health facility construction program (AS 29.90). If after review the legislature determines that continuation of these programs is in the public interest, a bill may be introduced to continue the programs.

* Sec. 21. The sponsor of a hospital or health facility construction project who is receiving or entitled to receive state aid under AS 29.90 on June 30, 1986, shall continue to receive state aid until the sponsor has received an amount which, combined with state matching money for construction of the hospital or health facility, equals 25 percent of the total project cost. Money received for construction may not be used for any other purpose.

* Sec. 22. AS 18.07.031 - 18.07.101, 18.07.111(1) - (4), 18.07.111-(7) - (9), 18.07.111(11), AS 29.90 and AS 47.80.140(b) are repealed.

* Sec. 23. AS 18.07.111(10) and AS 47.07.080(1) are repealed.

* Sec. 24. Sections 2, 12, 21, and 22 of this Act take effect July 1, 1986.

* Sec. 25. Sections 1, 3 - 11, 13 - 20, and 23 of this Act take effect immediately in accordance with AS 01.10.070(c).

THE LEGISLATURE OF THE STATE OF ALASKA
THIRTEENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. CSSSHB 19 (Finance)
Title Relating to C.O.N. and state aid for health facility
Requested by House Finance Date 4/13/83

II. FISCAL DETAIL
Agency Affected Dept. Health & Social Services
Program Category Affected Health Facility Development
BRU, Program, Or Subprogram(s) Affected Health Planning & Development
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
100 PERSONAL SERVICES		84,693	90,621	96,965	103,753	111,015
200 TRAVEL		27,000	28,890	30,912	33,076	35,391
300 CONTRACTUAL		70,000	20,000	20,000	20,000	20,000
400 COMMODITIES		2,000	2,140	2,290	2,450	2,621
500 EQUIPMENT		6,000	1,000	1,000	1,000	1,000
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC						
TOTAL		189,693	142,651	151,167	160,279	170,027

FUNDING (Thousands of Dollars)

GENERAL FUND		99,115	74,535	78,985	83,745	88,839
FEDERAL FUNDS		90,578	68,116	72,182	76,534	81,188
OTHER (Specify Source)						

POSITIONS

FULL TIME		2	2	2	2	2
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)

See Attachment A

IV. DATE 4/13/83 PREPARED BY Al Adams, Chair NPA
AGENCY House Finance Committee
PHONE 465-3706

Original: Legislative Finance
cc: Budget & Management
Prime Sponsor (First Legislator Named)

83-001 (Rev. 12/82)

ATTACHMENT A

100 Personal Services			
1) Executive Director	R24 $4,251 X 12 =		51,012
2) Clerk Typist III	R8 1,487 X 12 =		17,844
			68,856
	Benefits .23%		15,837
			$84,693
200 Travel and Per Diem			
5 Commission Members X 12 meetings			
X average cost of $450		=	27,000
300 Contractual (Data Processing Assistance)			70,000
400 Commodities			2,000
500 Equipment			
1) Desks, Chairs and Files			6,000
Word Processor			
			$189,693

Three existing Auditor III positions from the Division of Public Assistance will be transferred for Commission use as well as travel funds, etc.

Note that 47.7% of this budget will be supported with federal funds.

POSITION PAPER/Department of Health & Social Services

Position Paper

on

Sponsor Substitute for House Bill 19

"For an Act repealing the certificate of need program; and providing for an effective date."

Sponsor Substitute for House Bill 19 repeals those portions of AS 18.07.021 which provide the statutory authority for the Department to administer a certificate of need program and repeals references to certificate of need in other sections of the Statute as well.

The Administration supports Sponsor Substitute for House Bill 19 as it is currently written.

The Department recommends that the Committee review statutory provisions which relate to health facility development including the following:

Medicaid Programs

The state's participation in the Medicaid program (State dollars fund approximately 52 percent of total program costs) has grown from $1 million in 1972 to nearly $38 million in FY 82 and total costs including federal participation have grown from $2 million to nearly $74 million in this same period. Ninety-two percent of patients in Alaska's long term care facilities are supported by the Medicaid program which means that the state (and federal) government has nearly the full burden of all operational costs for the facility. These Medicaid costs increase when additional beds are added, new equipment is purchased or new services (including new types of manpower) are offered. The Division of Public Assistance must effect a provider agreement with any qualified provider who seeks this agreement.

Capital Budget 2990 Lic. Rep Stevens SB85 Const #

Alaska has provided substantial financial assistance in the development of health care facilities. The 12th Legislature provided more than $36.6 million by line item appropriation to expand one hospital, replace two others and provide planning assistance for two rural hospitals. The number of requests for state funding has steadily increased.

Revenue Sharing

Alaska has a revenue sharing program (AS 29.90.010) which provides 25 percent plus interest of hospital construction costs to all non-profit hospitals. This program, administered by the Department of Community and Regional Affairs, provides further support for hospital construction projects in addition to any front-end capital funds provided by the state. This additional health facility construction resource underscores the importance of determining the actual need

POSITION PAPER/Department of Health & Social Services

for construction, before the State is committed to pay for a major portion of such construction.

Non-profit hospitals each receive a quarter of a million dollars in operating assistance each year through the state's revenue sharing program (AS 29.89.030). Nursing homes and other health facilities also receive assistance based on the number of beds they have. There are no specific requirements as to how such funds are to be expended. Not only are existing health facilities assured of these funds in addition to other state support, but new facilities are encouraged by the availability of these funds.

Recommended by: Phoebe A Lindsey
Phoebe A. Lindsey, Director
Division of Planning, Policy and Evaluation

Date: February 18, 1983

Approved by: Robert London Smith
Robert London Smith, Ph.D.
Commissioner
Department of Health and Social Services

Date: 2/22/83

STATE OF ALASKA
PRELIMINARY STATEMENT OF FISCAL IMPACT

Bill No: House Bill 19 Date on Bill: 1/24/83
Title: An Act repealing the certificate of need program;and providing for an effective date
Sponsor: Representatives Fritz, Hayes, Zharoff, Cato, Lindauer, Szymanski
Requestor:

1. Estimated fiscal impacts on:

a. Expenditures:

			FY 83	FY 84	FY 85	FY 86			
Capital			0	0	0	0			
Operating			0	0	0	0			
Total			0	0	0	0			

b. Revenues:

Revenue			0	0	0	0			

2. Source of funds to offset fiscal impact of bill:

3. Assumptions:

4. Disclaimer:
This statement has not been reviewed by the OMB in the Office of the Governor. It does not represent the policy of the Sheffield Administration or the final estimate of fiscal impact.

Prepared By: Dave W. Williams DW Phone: 465-3038
Division: State Health Planning and Development Date: 2-14-83

Approved by Commissioner: Rosita Fowler Dowd, M. D. Date: 2/22/83
Department: Health and Social Services Date:

6. Distribution:
Original to Legislative Finance
Copy to OMB
Copy to Sponsor

STATE OF ALASKA
PRELIMINARY STATEMENT OF FISCAL IMPACT

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Title: An Act repealing the certificate of need program;and providing for an effective dat
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Total			0	0	0	0			

b. Revenues:

Revenue			0	0	0	0			

2. Source of funds to offset fiscal impact of bill:

3. Assumptions:

4. Disclaimer:
This statement has not been reviewed by the OMB in the Office of the Governor. It does not represent the policy of the Sheffield Administration or the final estimate of fiscal impact.

Prepared By: Dave W. Williams DW Phone: 465-3038
Division: State Health Planning and Development Date: 2-14-83

Approved by Commissioner: Robert London Smith, Ph.D. Date: 2/22/83
Department: Health and Social Services Date:

6. Distribution:
Original to Legislative Finance
Copy to OMB
Copy to Sponsor

POSITION PAPER/Department of Health & Social Services

Rec'd 5-27-83

Position Paper
S.S. for House Bill 19 am

An Act repealing the certificate of need program, amending or repealing provisions relating to state aid for health facilities, Medicaid and general relief medical assistance; and providing for an effective date.

Sponsor Substitute for House Bill 19 am proposes amendments to state law which primarily affect three areas of the Department of Health and Social Services' responsibility: 1) the certificate of need program, 2) coordination of the certificate of need program with the Alaska Medical Facility Authority, and 3) prospective reimbursement under the Medicaid and General Relief Medical Assistance Programs.

I. Certificate of Need

The bill effectively repeals the certificate of need program. The Administration supports this portion of SSHB 19 am.

II. Coordination of the Certificate of Need Program with the Alaska Medical Facility Authority

The bill repeals and reenacts AS 18.26.220. The apparent reason for the proposed changes in this portion of state law is to remove the references to the certificate of need program.

The Department of Health and Social Services supports this change in state law in order to maintain consistancy with the proposed repeal of the certificate of need program as set out in SSHB 19 am.

III. Prospective Reimbursement - Medicaid and General Relief Medical Assistance Programs

A. General Overview

Hospital and Nursing home rates in Alaska have traditionally been established retrospectively, that is, costs are estimated at the beginning of a fiscal year and an "interim payment" determined. At the end of the fiscal year, the total interim payments made is compared to the allowable costs of the facility. The difference is either collected from or paid to the facility. This process is referred to as "cost settlement".

Propsective payment, on the other hand, provides for establishment of the payment rate prior to the fiscal year as a result of discussions between each facility and the State, each facility must then operate and provide care at this predetermined rate for the fiscal period.

While the retrospective method assures providers that all of their allowable costs will be reimbursed, a fundamental weakness of these retro-

spective systems is the lack of incentives to control staffing levels, equipment purchases, wage increases, and service expansion.

In view of reduced federal revenues and a new state spending limit, Alaska needs improved cost containment and predictability from its medical reimbursement system. The system must not only consider price, but also eligible groups and service coverages before the budget year commences. It also must consider the differences in "rural" and "urban" health delivery problems.

B. Problems with Retrospective Cost-Based Reimbursement Systems

- Tendency toward ineffective cost containment -- The key problem with a retrospective system is the lack of incentives to control expenditures so that unnecessary costs are avoided.

- Dependence upon auditing and monitoring procedures -- A retrospective system must have a tight, effective auditing system to monitor costs in order to curb abuses of the system.

- Tendency of the system to become inflexible -- Decisions are often made by accountants based on "generally acceptable accounting principles" rather than on the merits of each individual facility's situation.

- State is uncertain of total program costs until the fiscal period is well over -- Final cost figures may not be known to the State until 6 months after a fiscal year ends.

- Cost Shifting occurs where unallowable costs under Medicaid are borne by other payors (insurance and private payors).

C. Advantages of a Prospective Payment System

- Based on the principle that predetermined rates will result in lower costs. A 1982 study by THE URBAN INSTITUTE concluded that prospective systems lower the rate of increase in hospital spending by several percentage points a year, after an initial start-up period.

- Predictability of costs to the State. Prices are agreed upon by the facilities and the State before the fiscal period starts.

- Predictability of revenues to the facilities. The industry can negotiate wages, purchases and other business decisions with a set service price in mind.

- The technique encourages development of more sophisticated budgeting and cost monitoring capabilities. These are desirable management tools and will permit the State to see how a facilities' budget is built and discuss their assumptions in each of the major cost categories.

D. Disadvantages of a Prospective Payment System

- Administrative costs are generally greater than those of a retrospective system. However, administrative costs vary greatly according to the design of the system, and as such, this factor is not of significant concern when compared to the total dollars being monitored in the health area.

- Arbitrary cost limiters ("FREEZES", "LIDS") may be introduced into the prospective system to balance costs versus revenues. This eventually places hospitals and nursing homes in a "no win" situation since the rates do not fairly reflect efficiently run facilities' costs.

- If rates are not applied industry wide, cost shifting can still occur if Medicaid rates are set unrealistically low by the State based on arbitrary limiters.

E. Operation of a Prospective Payment System

There are a wide variety of prospective payment systems operated in the acute care and long term care sectors around the nation.

A common element of a prospective rate payment setting mechanism is an allowable rate of increase in per diem cost for the following year. This percentage is normally calculated through application of economic indicator such as U.S. Department of Labor wholesale and consumer price indexes. The percentage is then routinely applied to actual cost from the previous period to arrive at the prospective rate. Determination of allowable rates of increase can be undertaken either on an individual facilities or groups of facilities.

Another element of a prospective payment system is more precisely defined cost categories combined with a uniform method of reporting costs to the State. A common cost breakdown would be labor vs. non-labor with further categorization inside these areas. The following example uses "natural" expense categories in reporting facility costs.

- Labor expenses
  - physician's fees
  - management
  - clerical
  - technical (e.g., LPNs', therapists)
  - registered nurses
  - household services (e.g., dietary, housekeeping workers)

- Non-labor expenses
  - food
  - utilities
  - drugs and supplies
  - maintenance of personnel
  - other

While some level of categorization is necessary to assure accuracy of prediction, the model outlined above may require an excessive level of accounting time and expertise for some of Alaska's smaller facilities.

The compromise approach shown below may suffice:

- Salaries and fringe benefits
- Non-labor expenses
  - administrative and general
  - household and maintenance
  - dietary
  - professional care

F. State Reimbursement Trends

To date, approximately thirty-four states have instituted a prospective system of reimbursement for nursing home services under Medicaid, and sixteen states have instituted a propsective system of reimbursement for hospital services under Medicaid. These prospective systems have taken many forms, each state's structure is a little different. However, they share the same philosophical purposes: "to encourage economy and efficiency, and to establish a uniform system of accounting, budgeting, and reporting in determining a health facility's future reimbursement".

G. Why Alaska Should Consider Prospective Payment Now

1. Total overall spending is growing at 20% each year in Medicaid/GR Medical.

   In any period, total spending is always a function of: 1) the number of recipients, 2) the volume of services used, and 3) the unit price of service. With an automatic cost-of-living increase that expands Alaska's eligible population, coupled with no unit price control or volume limits, Alaska currently has no ability to effectively control growth in medical costs.

   According to a recent study by THE URBAN INSTITUTE, Medicaid payments rose at an annual rate of 15.5 percent from FY73 to FY79 nationally. Alaska had the highest annual rate of increase at 41.8 percent during this same period. Since FY79, costs have increased in excess of 20 percent annually in Alaska.

   These three factors (recipients, volume, and unit price) need to be considered collectively in any fiscal year. Currently, critical decisions concerning eligible populations, service coverages and unit price are handled independent of each other and do not produce a final cost figure until the fiscal year is past. If total spending is to be contained at a level below 20%, these factors must be considered collectively before each fiscal year starts.

2. Federal funding for Medicaid is reduced in FY84 and later years. The State is facing an unknown dollar cutback in federal funding for FY84. Unless additional State funding replaces these lost federal revenues, critical decisions must be made to bring program spending in line with available resources.

3. Prospective Systems reduce costs in the long term. The Urban Institute recently concluded that "a concensus is now developing that

prospective rate setting is effective in lowering the rate of increase in hospital spending by several percentage points a year, at least in mature rate setting programs after an initial start-up period".

H. Why Doesn't the Department of Health and Social Services Simply Adopt Prospective Payment by Regulation?

The Legislature must specifically endorse adoption of a prospective system in Alaska. The Alaska Attorney General has ruled in a 1982 opinion that present Alaska Statutes prevent adoption of a prospective payment system by regulation. The Legislature must change Alaska Statutes to clearly authorize the Department to adopt a prospective system.

I. What Options Exist?

1. Do Nothing. This strategy would leave reimbursement in the present retrospective environment and require the Department to pass reductions in federal revenues on to hospitals and nursing homes through reduced rates. Most recent calculations place hospital and nursing home revenue reductions at 8% and 24% respectively for FY84. This strategy would not require any additional funds beyond the FY84 Governor's request for Medical Assistance but would severly impact Alaska facilities.

2. Remain on retrospective system and replace lost federal revenues with State funds, if State law permits. This strategy will require replacement funds and may require a statute change as well. There is some doubt whether the present statutes would permit the Department to pay rates in excess of the federal limits.

3. Same as option #2 but reduce persons eligible and medical services available. Under existing Alaska law, the Department is empowered to eliminate certain medical services and certain eligibility groups if funds were deemed inadequate for FY84. If it were determined that the Department could pay in excess of new federal limits with all State funds, or legislation were passed to permit this, the Department could make reductions in services and eligible groups to stay within its FY84 request.

4. Adopt Prospective System and replace lost federal revenues with State funds. This strategy will cost roughly the same as Option #2 but FY84 costs could be predicted with greater certainty. Assuming no changes were made in medical services covered or persons eligible, this option would save the State from 1 to 3% annually compared to Option #2 after the initial start-up period.

5. Adopt Prospective System but reduce persons eligible and medical services available. Herein lies the true value of a prospective system. Once the prospective rules are established and the rates (unit price) for services agreed upon for the fiscal year, eligible groups and medical services are then balanced aginst unit price to operate within the available appropriation. If no changes were made in persons covered or services offered, the price for this option would be the same as Option #4. If major reduction in eligibles or

services were made, the costs for this option could be reduced proportionately.

6. Seek Relief from Congress. This is always an option but not one with as much potential in light of Alaska's present financial image. Nonetheless, there is provision within the new federal changes for special negotiation with the Secretary of Health and Human Services regarding "rural" hospitals. Alaska could pursue this option in conjunction with one of the strategies described in Option 1 through 5 above.

J. Summary

Alaska must balance eligible populations, medical services covered and unit price against available funds to define an affordable FY84 medical program. While a prospective system will not in and of itself make this totally possible, it could provide a business environment in which critical decisions will be made before the fiscal year starts.

Department's Position

The Department of Health and Social Services supports this legislation as proposed.

5/25/83
Date

Robert London Smith
Robert London Smith, Ph.D.
Commissioner
Department of Health and
Social Services

May 24, 1983
Date

John Pugh
John Pugh, Deputy Commissioner
for Social Services
Department of Health and
Social Services

May 19 1983
Date

Daniel J. Meddleton
Daniel J. Meddleton, Director
Division of Planning, Policy, and
Program Evaluation

May 19, 1983
Date

Rod Betit
Rod Betit, Director
Division of Public Assistance

STATE OF ALASKA
FISCAL NOTE

Revision Date , 1983

I. REQUEST
Bill/Resolution No.: SSHB 19 am
Title: Prospective Rate Setting
Sponsor:
Requestor:

II. FISCAL DETAIL
Agency Affected: Health and Social Services
Program Category Affected: Medical Assistanc
BRU, Program of Subprogram(s) Affected: Medicaid/General Relief Medical

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
OPERATING						
100 PERSONAL SERVICES		84.7	90.6	97.0	103.8	111.0
200 TRAVEL		27.0	28.9	30.9	33.1	35.4
300 CONTRACTUAL		70.0	20.0	20.0	20.0	20.0
400 COMMODITIES		2.0	2.1	2.3	2.4	2.6
500 EQUIPMENT		6.0	1.0	1.0	1.0	1.0
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC						
TOTAL OPERATING		189.7	142.6	151.2	160.3	170.0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		99.1	74.5	79.0	83.7	88.8
FEDERAL FUNDS		90.6	67.1	72.2	76.6	81.2
OTHER (Specify Source)						

POSITIONS:

FULL-TIME		2	2	2	2	2
PART-TIME						
TEMPORARY						

III. SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

IV. ANALYSIS: Attach a separate page for any Analysis

Prepared By: Penny L. Harris
Division: Public Assistance
Phone: 465-3355
Date: 5/24/83

Approved by Commissioner: Robert London Smith
Department: H&SS
Date: 5/25/83

Distribution:
Original to Legislative Finance
Copy to Office of Management and Budget (for Legislature introduced bills)
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Copy to Requestor (if different from Sponsor)

3/8/83

FISCAL NOTE REVIEW

100	Personal Services			
	1) Executive Director	R24	$4,251 X 12 =	$51,012
	2) Clerk Typist III	R 8	1,487 X 12 =	17,844
				68,856
	Benefits .23%			15,837
				84,693
200	Travel and Per Diem			
	1) 5 Commission Members X 12 meeting X $450			$27,000
300	Contractual (Data Processing Assistance)			$70,000
400	Commodities			$ 2,000
500	Equipment			$ 6,000
	1) Desks, Chairs and Files			
	Word Processor			
				$189,693

Three existing Auditor III positions from the Division of Public Assistance will be transferred for Commission use as well as travel funds, etc.

FY'85 and succeeding fiscal years based on 7 percent increase.

Introduced: 1/24/83
Referred: Health, Education &
Social Services and Finance

BY FRITZ, HAYES, ZHAROFF, CATO, LINDAUER, SZYMANSKI, MCBRIDE AND BUSSELL

IN THE HOUSE

SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 19 am

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act repealing the certificate of need program, amending or repealing provisions relating to state aid for health facilities, Medicaid and general relief medical assistance; and providing for an effective date."

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

* Section 1. AS 18.07.021 is amended to read:

Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY. The division of planning, policy, and program evaluation [OFFICE OF PLANNING AND RESEARCH] in the department is the state health planning and development agency designated under 42 U.S.C. Sec. 300m(b)(3), (Sec. 3, P.L. 93-641) [SEC. 1521(b)(3), P.L. 93-641]. The division [OFFICE] shall perform the functions enumerated under 42 U.S.C. Sec. 300m-2(a)(1) - (3), (a)(6) - (8), (b) and (c), (Sec. 3, P.L. 93-641) [SEC. 1523,P.L. 93-641, ADMINISTER THE CERTIFICATE OF NEED PROGRAM OUTLINED IN AS 18.07.041 - 18.07.111, AND OTHER FUNCTIONS PRESCRIBED IN THIS CHAPTER].

* Sec. 2. AS 18.07.111 is amended by adding a new paragraph to read:

(13) "division" means the division of planning, policy, and program evaluation in the Department of He :h and Social Services.

* Sec. 3. AS 18.26.220 is repealed and reen ed to read:

Sec. 18.26.220. FACILITY COMPLIANCE ' .H HEALTH AND SAFETY LAWS AND LICENSING REQUIREMENTS. In order to receive financial assistance under this chapter, a medical facility shall comply with AS 18.20 and

the licensing requirements of this chapter.

* Sec. 4. AS 29.89.030(a)(1) is repealed and reenacted to read:

(1) to a municipality that has the power to provide hospital facilities and services and that exercises that power, $250,000 per hospital for those hospitals with 10 or more acute care beds, and $50,000 per hospital for those hospitals with less than 10 acute care beds; money received under this paragraph may be used only for hospitals and shall be apportioned among qualifying hospitals as the municipality determines;

* Sec. 5. AS 47.07.070 is repealed and reenacted to read:

Sec. 47.07.070. PAYMENT TO HEALTH FACILITIES. (a) The commission shall determine prospectively the rate of payment to a health facility under this chapter and AS 47.25.120 - 47.25.300 based on a fair rate for reasonable costs incurred by the facility. The commission shall by regulation list the factors it considers in making its rate determinations under this section.

(b) In determining a rate of payment to a health facility under this section, the commission shall consider the proportionate share of the facility's financial requirements for patient care for

(1) costs of current operations, including salaries and wages; purchased services, supplies, insurance, leases, depreciation, taxes, interest expense, maintenance and other health facility operating expenses; and

(2) education, research, and appropriate capital development.

(c) In determining a rate of payment to a health facility under this section, the commission may consider whether the rate of utilization of the facility has been reduced because of improvement or careless development of the facility.

* Sec. 6. AS 47.07 is amended by adding new sections to read:

Sec. 47.07.071. REPORTS BY HEALTH FACILITIES. Not later than 120 days after the end of each fiscal year of a health facility, the facility shall submit to the commission a report on the facility's financial performance during the fiscal year.

Sec. 47.07.072. REPORT BY THE COMMISSION. Not later than September 30 of each year, the commission shall submit to the governor a report on the prospective payments made under this chapter during the current fiscal year and an estimate of the prospective payments that will be made during the remainder of the current fiscal year and the next fiscal year. The report shall state the assumptions that are used as a basis for the estimates.

Sec. 47.07.073. UNIFORM ACCOUNTING, BUDGETING, AND FINANCIAL REPORTING. (a) The commission by regulation shall require a uniform system of accounting, budgeting, and financial reporting for health facilities receiving prospective payments under this chapter. The regulations shall provide for the reporting of revenues, expenses, assets, liabilities, and units of service. The commission shall specify the date the system becomes effective for each health facility.

(b) In adopting regulations under this section, the commission shall consider

(1) accounting, budgeting, and financial reporting procedures used by health facilities;

(2) variations among health facilities in the types of health care services provided by health facilities;

(3) other factors the commission considers relevant, including the size and organizational structure of health facilities and the methods used by health facilities to obtain payments.

(c) The commission may waive or modify a requirement for accounting, budgeting, or financial reporting for a health facility if waiver or modification is

(1) necessary to avoid excessive costs to the facility; and

(2) consistent with the policies of this chapter.

(d) Notwithstanding other provisions of this section, the commission may, by regulation, modify the system of accounting, budgeting, and financial reporting required under this section for a health facility having less than 25 acute care beds in order to reduce the operating costs of that facility.

Sec. 47.07.074. AUDITS AND INSPECTIONS. As a condition of obtaining payment under AS 47.07.070, a health facility shall allow

(1) the department and the commission reasonable access to the financial records of medical assistance beneficiaries; and

(2) inspection of financial records by state and federal agencies to the extent required by federal law.

Sec. 47.07.075. APPLICATION OF ADMINISTRATIVE PROCEDURE ACT. Actions of the commission under AS 47.07 and AS 47.25.120 - 47.25.300 are subject to the provisions of the Administrative Procedure Act (AS 44.62).

* Sec. 7. AS 47.07.080 is amended by adding new paragraphs to read:

(6) "commission" means the Medicaid Rate Commission;

(7) "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic.

* Sec. 8. AS 47.07 is amended by adding new sections to read:

ARTICLE 2. MEDICAID RATE COMMISSION.

Sec. 47.07.110. MEDICAID RATE COMMISSION ESTABLISHED. The Medicaid Rate Commission is established in the Department of Health and Social Services.

Sec. 47.07.120. COMPOSITION OF COMMISSION. The commission consists of five members as follows:

(1) the chief executive officer of a health facility that is licensed by the state but not owned or operated by the state or federal government and that is subject to the budget review process under this chapter;

(2) the commissioner of administration, the commissioner of health and social services, or the appointed designee of either commissioner;

(3) a physician licensed to practice medicine in the state who is actively engaged in the practice of medicine and who is not employed by the state;

(4) a certified public accountant with relevant experience;

(5) a person representing consumers of health services who does not have a direct or indirect interest in an entity that provides health care services.

Sec. 47.07.130. APPOINTMENT OF MEMBERS. Members of the commission are appointed by the governor and serve at the pleasure of the governor.

Sec. 47.07.140. TERM OF MEMBERSHIP. The term of a member of the commission appointed under AS 47.07.120(1), (3), (4), or (5) is three years. A member may not be appointed to a successive term. The terms of the members shall be staggered. A member appointed to fill a vacancy serves for the unexpired term of the member. A term shall be measured from January 1 of the year in which the term of the vacant position begins, regardless of when the vacancy is filled.

Sec. 47.07.150. COMPENSATION. A member of the commission serves without compensation but is entitled to per diem and travel expenses authorized by law for boards and commissions under AS 39.20.180.

Sec. 47.07.160. OFFICERS. At the first meeting of each year, the commission shall elect a chair from among its members.

Sec. 47.07.170. MEETINGS AND QUORUM. The commission shall meet as often as is necessary to conduct its business. Three members of the commission constitute a quorum.

Sec. 47.07.180. DUTIES. The commission shall review proposed payment rates and budgets of health facilities and establish payment rates for health facilities under this chapter and AS 47.25.120 - 47.25.300.

Sec. 47.07.190. EMPLOYMENT OF PERSONNEL. The commission may employ and determine the salary of an executive director. With the approval of the commission, the executive director may select and employ additional staff. The commission shall be assisted by the officers or personnel of the department as the commissioner of health and social services shall direct. The executive director of the commission is in the exempt service under AS 39.25.

* Sec. 9. AS 47.25 is amended by adding a new section to read:

Sec. 47.25.195. PAYMENT TO HEALTH FACILITIES FOR TREATMENT OF NEEDY PERSONS. (a) The department may make payments to a health facility for the treatment of a needy person.

(b) A health facility receiving a payment under this chapter is subject to the requirements of AS 47.07.070 - 47.07.075.

(c) For purposes of this section, "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health

clinic, and outpatient surgical clinic.

* Sec. 10. INTERIM PROSPECTIVE PAYMENT SYSTEM. The department shall establish an interim system of prospective payments for health facilities under this Act for the period July 1, 1983 to June 30, 1984.

* Sec. 11. The sponsor of a hospital or health facility construction project who is receiving or entitled to receive state aid under AS 29.90 on the day preceding the effective date of this Act shall continue to receive state aid until the sponsor has received an amount which, combined with state matching money for construction of the hospital or health facility, equals 25 percent of the total project cost. Money received for construction may not be used for any other purpose.

* Sec. 12. AS 18.07.031 - 18.07.101, 18.07.111(1) - (4), 18.07.111-(7) - (11); AS 29.90; AS 47.07.080(1) and AS 47.80.140(b) are repealed.

* Sec. 13. This Act takes effect immediately in accordance with AS 01. 10.070(c).

CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Alaska's Certificate of Need (CON) Law was enacted by the State Legislature in 1976, following passage of Public Law 93-641, the National Health Planning and Resource Development Act of 1974. Provisions in the CON law require that non-federal health care institutions apply for and receive a Certificate of Need from the State of Alaska before proceeding with major capital investments which will result in new construction, alterations or renovations, and/or new services. The Thirteenth Alaska Legislature currently has before it companion bills, HB 19 and SB 85, which provide for repeal of the CON law. The purpose of this paper is to review the data available on the effectiveness of the CON process, both nationally and within the State of Alaska, and to present alternatives for consideration by the Legislature regarding public review of capital expenditures for health care facilities.

Evidence is presented that the CON program has had an effect on limiting the amount of capital expenditures. Furthermore, current economic research has demonstrated that, for every dollar of capital investment made in a health care facility, an accompanying increase in operating costs can be expected amounting to 184% of the original investment in ten years.

Evidence gathered on Alaska's experience with the Certificate of Need program indicated that it has been effective in deterring and/or guiding capital investment within the health-care industry and has stimulated improved planning within the health-care institutions themselves. Examples are presented which illustrate how the process created this impact.

Several issues are discussed relating to recognized concerns within the current CON process. These issues include: 1) costs attendant to developing a CON application; 2) delays in the review process; 3) loss of community control; 4) marketplace economics; and, 5) the dollar-threshold limits which require a CON.

The conclusion drawn from this review was that, although there are problems with the current CON process, revision of the law is preferable to outright repeal. Recommendations for revision of the law are provided and include:

1. Raising threshold levels.
2. Exempting non-clinical capital expenditures.
3. Expediting reviews of equipment replacement.
4. Specifying time limits on reviews.
5. Providing legislators with information on the outcome of reviews in their districts.
6. Providing for a sunset review of the process.

CERTIFICATE OF NEED PROGRAM

PURPOSE

The most controversial aspect of the health planning effort, in Alaska and nationwide, has been the Certificate of Need (CON) program. Borrowed from public utility regulations, the earliest CON program was enacted by New York in 1964. Twenty-six other states instituted CON programs in the next ten years, and, with the passage of Public Law 93-641, CON was mandated for all states. Alaska's Certificate of Need statute (18.07.031-.111) was enacted by the State Legislature in 1976 and amended in 1981.

As originally designed, the CON program was implemented to curb rapidly escalating costs of health care by stemming uncontrolled capital investments in new health-care facilities, services, and high-technology equipment. To accomplish this goal, the CON program had several primary objectives: 1) to prevent unnecessary duplication of services and facilities; 2) to reduce the number of available hospital beds or at least not allow the growth of hospital beds to exceed guidelines established in the State Health Plan; 3) to promote an equitable and efficient allocation of resources; and 4) to determine if less costly alternatives to expensive capital expenditures were available to accomplish the same purpose.

WHO MUST APPLY

The State of Alaska requires approval of capital expenditures for projects which meet or exceed certain thresholds:

1. Capital expenditures in excess of $150,000 toward building, improving, or purchasing a health care facility, including lease or purchase of equipment, costs of any study surveys, designs, and site acquisitions and preparations.

2. Any change within a two-year period in the licensed bed capacity of a health care facility amounting to 10 beds or 10 percent, whichever is the lesser, which increases or decreases the number of beds or redistributes beds among different categories of service.

3. Any addition or elimination of a major type of service offered in or through the health care facility.

A project meeting or exceeding these thresholds is required to obtain a Certificate of Need from the State of Alaska prior to implementation.

THE PROCESS

An applicant enters the CON review process by submitting a "Letter of Intent" to the Department of Health and Social Services (DHSS) and to the appropriate health systems agency describing briefly the scope of the proposed activity. If the DHSS determines that the project is subject to CON review, the applicant develops a formal application and submits it to the State agency and the regional health systems agency. In most cases, a pre-application conference is scheduled with the applicant to minimize any potential misunderstandings and to achieve an agreement on what would represent a successful application. Once the State agency certifies that the application is "complete" -- that it contains sufficient information necessary to conduct an objective review -- the agency has 90 days to review the application and to submit an analysis to the Commissioner of DHSS for final action. Within the 90-day review period, the regional health planning agency has 60 days to review and seek public comments on the appropriateness of the proposed application. The HSA submits its findings and recommendations to the Commissioner. Once the Commissioner has considered the information that has been submitted, he decides whether or not to issue a Certificate of Need to the applicant. The Commissioner notifies the applicant in writing of the decision. Copies of the decision are sent to the Health Systems Agency and are published in regional newspapers.

EFFECTIVENESS

Nationwide

Nationally, credible information is just beginning to emerge regarding the effect of capital expenditures review. Although this topic has been of interest for many years, much of the early literature is of little value because of a basic lack of understanding about the process and outcome of capital expenditure review programs.[1] Two recently completed studies in the State of Massachusetts have reported CON impacts.[2,3] The first analyzed hospital capital investment among short-term general voluntary hospitals between 1967-1976. The results were that, by 1976 and beyond, CON review reduced all dimensions of project scale and cost by as much as two-thirds of that originally proposed. The second study found that the formal and informal actions of the CON agency from 1972-1976 resulted in small, but statistically significant, reductions in the rate of hospital investment.

Two studies conducted in 1982 by Arthur D. Little, Inc., shed additional light on the potential impact of capital expenditures review.[4,5] The first study analyzed the effect of capital expenditures review decisions in five states: Colorado, Florida, Maryland, Massachusetts, and Oregon (chosen for their geographical and regulatory differences). Based on their analysis, CON programs appeared to be effective in limiting the amount of capital expenditures undertaken. Furthermore, they discovered that, for every dollar of capital investment, there was a definite increase in operating costs. They projected that, over a ten-year period, a dollar of capital investment generates additional operating costs with a present value of $1.84 (exclusive of

depreciation and debt service). They concluded from these results that CON programs have the potential to play an important role in curbing hospital cost inflation.[4]

A second report by Arthur D. Little, Inc., involved an analysis of information from a six-state study.[5] For the states of Virginia, South Carolina, Washington, New Jersey, Iowa and Colorado, Arthur D. Little undertook a review of Certificate of Need programs for the twelve-month period beginning July 1, 1979 to June 30, 1980. Three significant findings were reported: 1) certain capital costs were not incurred as a result of the CON review program; 2) the objectives contained in individual state plans and health systems plans tended to deter capital expenditure projects; and, 3) pre-application conferences -- health planners and providers working together to avoid project denial -- were effective means of reducing the "administrative costs" of the review process as well as excessive capital expenditures.[5]

Alaska

Currently (February 1983) there are five projects under review by the Department of Health and Social Services that total $106,000,000. Two additional applications are anticipated, totalling $20,820,000. These seven applications ($126.8 million) provide an interesting contrast with the more than 30 projects which were approved for $149,000,000 in the previous five years (1977-1982).

Two projects with a combined total of $12,400,000 have been denied during the past five years. In addition, several other Letters of Intent have been received by the Department for which applications were never received. It is impossible to estimate how many applications or letters of intent were never submitted because of the presence of the CON law.

The Alaska CON Program has been effective in accomplishing three things. First, it seems reasonable to expect that CON has deterred misdirected projects that could not withstand the test of public scrutiny. It has, therefore, acted to uphold existing plan standards. Secondly, it has guided institutional actions into areas which are compatible with the goals and objectives of the State as reflected in State and regional health plans. Thirdly, the presence of the CON program has promoted better planning on the part of the health care institutions throughout the State.

Deterrent Effects

Although the deterrent effect of Certificate of Need is admittedly difficult to demonstrate, there is evidence from the number of "Letters of Intent" which never resulted in an application that CON is a deterrent. A specific example of this phenomenon was observed during a recent effort by four different applicants to provide inpatient alcoholism treatment services in and around Anchorage. The Department of

Health and Social Services and the local health systems agency identified a need for 40-80 alcohol-treatment beds in the area. Due to pre-application planning, only two of the four applications were completed for final consideration. Both were subsequently approved.

Improved Institutional Planning

Situations in which the CON process provides expert guidance and stimulates better institutional planning do not always result in smaller, less-expensive projects. For example, Valley Hospital in Palmer submitted an application to complete a minimal and temporary renovation of their 30-year old facility at a cost of $2,000,000. Part of the renovation included additional insulation to prevent heat loss through the roof. At the suggestion of the Department, a structural engineer was asked to study the ability of the roof to withstand the increased load of snow which would not be melted because of the insulation. The Department also requested a life-cycle cost analysis which would determine the cost of a temporary renovation as opposed to costs of major renovation. The results of these inquiries demonstrated that the roof was not designed to withstand the extra load of snow and that, when total operating expenses and capital costs were considered for a 25-year period, it would be less expensive to forgo the minimal renovation and proceed with a major renovation. The result of this review was an approval for a major renovation project -- at a long-term cost savings.

Petersburg General Hospital filed a letter of intent for $3,400,000 to renovate an existing acute care facility. Following an architectural assessment of the facility and a life-cycle cost analysis requested by the State, it was determined that the cost of new construction would be preferable to renovation. Subsequently, a CON was approved for $7,150,000. Obviously, the CON process is not punitive, but rather seeks to use health care resources to gain the maximum benefit for the community.

Hospitals in Homer and Fairbanks submitted proposals for review which contained "shelled-in" space for which no use was intended for the immediate future. In Homer, the Department requested further assessment of the situation to identify a solution to future use of the shelled-in space. As a result the plans were redrawn for the renovation and expansion and included the proposed use of the shelled-in space.

Better Conformance with Identified Community Needs

In Fairbanks, the CON process stimulated a community discussion of the need for inpatient psychiatric services and a concern for approving the construction of two shelled-in floors that did not have an identified use. Because of discussions at the local level during the review by the health systems agency, the hospital agreed to specify the intended use of the shelled-in space and, furthermore, to enter into a planning process with the community during the following year to determine the most appropriate configuration for the proposed services.

Summary

Although it is difficult to place a dollar figure on the impact of the Certificate of Need program over the past six years, it appears that Alaska's program has effectively deterred and guided capital investment within the health care industry and has stimulated improved planning within the institutions themselves. Because of the CON program, Alaskans have saved millions of dollars in operating costs which would have resulted from unneeded expansion of facilities and services. Moreover, the State Legislature and the Administration should feel some measure of assurance that, because of the CON process, the millions of dollars in public funds that have flowed from the State to health care facilities for construction and operation are being used for projects which meet an identified need, do not duplicate existing services, and are financially feasible.

PROBLEMS WITH THE CON PROCESS AND RECOMMENDATIONS FOR IMPROVEMENT

INTRODUCTION

Proponents and opponents of the Certificate of Need program agree that the current CON process requires substantial changes. Opponents cite several reasons for their decision to push for repeal of the current law. Among the reasons are: 1) significant costs are involved in developing a CON application and proceeding through the review; 2) delays in implementation are caused by an extended review period; 3) the CON process removes community control; 4) market-place economics should control capital investment; and 5) threshold limits which trigger a CON review are too low.

COSTS

No one denies that there are costs attendant to developing a CON application. The majority of those costs, which have been estimated to run as high as $40,000 for the more complex projects, can be attributed to personnel costs. Most of these costs would continue in the absence of CON if a facility did a credible job of planning for future services. In order to gain public support, justify the financial feasibility of a construction project, and obtain adequate architectural designs, planning still must occur. The costs of institutional planning will not disappear in the absence of CON.

DELAYS

Extended review schedules have in some cases resulted in delays in construction start-up time which have been not only frustrating but also costly. It seems reasonable that the cause for these delays can be identified and corrected by revising the regulations regarding CON review. For example, provisions could be made to expedite review of capital equipment replacement and to set a time limit for a decision by the Commissioner subsequent to a recommendation by a regional health planning agency. Also, by raising the threshold limits which require a CON, there will be approximately 25% fewer reviews to do. This should improve the efficiency of the review process.

COMMUNITY CONTROL

Concern has been expressed that the CON process removes community control from local jurisdictions in the case of municipally-owned facilities and local advisory boards with respect to corporately-owned facilities. However, local governments and advisory boards do not necessarily maintain a regional or statewide perspective when it comes to considering new services and facilities. In other words, persons who

serve on local hospital advisory boards are chosen for their expertise and dedication in local issues; often, however, a project will have regional or statewide implications that cannot be properly addressed at the local level. The CON process, at the very least, offers local, regional and statewide perspectives on the need and appropriateness of a proposed project. Instead of removing community control, the CON process bestows some control on the community at large.

In addition, a trend is evident that an increasing amount of public funds are being appropriated by the legislature for construction and renovation. It seems reasonable that in a time of decreasing state revenues, citizens should have an opportunity to influence the distribution of these funds so that they meet state and regional needs instead of local demand. The CON process ensures public participation in these decisions.

MARKETPLACE ECONOMICS: COMPETITION vs. "REGULATION"

In recent years, there has been a popular theory that the problems in U.S. health services can be blamed on excessive government intervention and regulations. It has been argued that high costs and related problems could be solved by a "return to the free market and competition."[6] Two recent articles argue to the contrary.[7,8]

Roemer and Roemer, well-known health-economics experts, examined the past and present operations of free trade and competition in the health care system and found that not one of at least five conditions necessary for competition existed.[7] In addition, they found that the free market created a geographic maldistribution of health manpower, causing serious problems for rural populations. Furthermore, they discussed the paradoxical problem which has been demonstrated for every component of the health care industry of "supply creating demand" rather than the reverse, which is true in an effectively operating market. Supply creates demand in the health care industry fundamentally because the seller (doctor) rather than the buyer (patient) makes most of the decisions on what health services are to be obtained.[7]

Needlemen, another health economist, expressed a similar opinion.[8]

> An effective market is one in which there is competition on the basis of both price and quality, and in which those who sell services are limited in their ability to influence the volume of services they sell and are constrained in the prices they set by competitive pressures. By this definition, an effective market for health care services does not exist in most communities. Competition exists but it is rarely price competition; indeed the nature of current competition based on scope of services, amenities, and convenience is to encourage price increasing behavior. (Emphasis added).[8]

Arthur D. Little, Inc., summarized the policy implication of the debate surrounding competition and regulation. They reported that, in the absence of Certificate of Need regulations, hospitals will compete more vigorously by offering improved facilities to recruit physicians and patients. The resulting "building boom" will drive up operating expenditures over the next ten years by $1.84 for every dollar invested, exclusive of depreciation and debt service.

THRESHOLD LIMITS

Alaska regulations specify that a CON is required for any capital expenditure in excess of $150,000. There is general agreement that this threshold is far too low. Federal regulations have already changed to accomodate a significant increase in CON thresholds. The threshold levels which trigger a CON review should be increased from $150,000 to at least $600,000 for capital expenditures; $400,000 for major medical equipment; and $250,000 for operating expenses associated with new services.

CONCLUSIONS

Recent evidence nationally and available information from the Certificate of Need Program in Alaska indicate that the program has been effective in deterring unjustified projects, guiding capital investment projects, and stimulating improved institutional planning. Together these effects have served to meet the health care needs of the public, prevent duplication of costly services, and restrain the increasing costs of health care. Acute problems with the CON process are correctable by amending the law.

Options available to the Legislature can be placed into three categories: 1) keep the law as it is and maintain the status quo; 2) repeal the law in its entirety; or, 3) revise the law to correct recognized problems.

MAINTAIN CURRENT CON PROCESS

The State would continue to operate the program in its current form. This option assumes the CON process is working efficiently and requires only minor changes.

Because of recognized problems, this option appears to have little merit. Threshold levels are too low, most non-clinical expenditure reviews are a nuisance for applicants and reviewers, and delays in the review process are unacceptable.

REPEAL THE CON LAW

This option assumes that the Certificate of Need process has been entirely ineffective and that marketplace incentives will arise to control capital investments and health care costs.

It also assumes that public review of health care capital expenditures are unimportant and that health care consumers should not have a voice in determining the appropriateness of services in their community.

A competitive pricing market does not exist within the health care services industry of any community in Alaska. In addition, the State of Alaska did not renew its Section 1122 agreement with the federal government in 1981 because the Certificate of Need law was in place. (Section 1122 of PL 92-603 required that health care facilities, which received federal monies under Titles XVIII and XIX, be subject to review to ensure consistency with state health plans.) Repeal of the CON law would leave the State entirely without a capital expenditure review process for health care facilities; therefore, the State would have to rely principally on either the competitive market or incentives established under some kind of a prospective reimbursement system to control costs and allocate resources. (Hospitals are currently reimbursed by the federal government under Medicare and Medicaid on a retrospective basis; that is, after the costs have already occurred. Under this

reimbursement mechanism, there is no real incentive for containing costs. Prospective reimbursement, on the other hand, would require that hospitals negotiate the rate or cost of a service a year in advance. The government and other third-party insurers would reimburse the hospital only at the negotiated rate; therefore, costs exceeding the rate would be borne by the hospital, and, conversely, the hospital would make money if costs were kept below the negotiated rate.)

Because a competitive pricing market does not exist anywhere in Alaska, eliminating the CON program will likely lead to new, unneeded services and facilities which will result in increased operating costs. These costs are passed directly on to the buyers (patients and taxpayers).

Prospective reimbursement, on the other hand, comes in various forms and generally has been found to be more difficult to enact and implement than Certificate of Need. Generally speaking, prospective reimbursement is likely to be successful only where there has been political support for Certificate of Need.

Finally, repeal of CON serves the interests of the health services establishment only. Those who control health-care costs would also be controlling capital investments. Consumers could not have a voice in determining the most appropriate and affordable level of service for their community or region.

MODIFY THE CON PROCESS

This option assumes that the CON program has been effective and can be modified to make it more efficient. The scope of the CON program could be scaled back by raising threshold levels and exempting certain non-clinical capital expenditures. Under this option, the CON program could be reduced further if a market capable of insuring an appropriate allocation of services emerged or to complement a prospective reimbursement system.

RECOMMENDATIONS

The Alaska Health Coalition recommends that negotiations take place among members of the Alaska State Hospital Association, the Legislature, and the Administration to work out revised CON regulations.

The Coalition further recommends that the following revisions be considered as a starting point for the negotiations.

1. Increase the threshold level which triggers a CON review from $150,000 to at least:
   a. $600 000 for capital expenditures
   b. $400,000 for major medical equipment
   c. $250,000 for operating expenses associated with new services.

2. Exempt all non-clinical capital expenditures. The bill should indicate that non-clinical services which are not subject to review include, but are not limited to: parking, telephone systems, day care, mailrooms, heating and air conditioning, blood bank, dietary/cafeteria, laundry and linen, medical records, business office, housekeeping, central supply, library, reception, and data processing. This exemption would apply only if one of these non-clinical projects was the main purpose of the application. For example, a project proposing a new facility could still include review and consideration of the non-clinical activity if it were part of a larger project.

3. Expedite review of capital equipment replacement.

4. Specify a time limit for a decision by the Commissioner subsequent to a recommendation by the regional health planning agency.

5. Provide that each legislator be informed of all projects in his/her district, especially regarding the outcome of the review.

6. Consider a sunset provision of four or more years to review effectiveness of the CON process.

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APPENDIX

NATIONAL HEALTH PLANNING AND DEVELOPMENT ACT OF 1974

INTRODUCTION

Public Law 93-641, (National Health Planning and Resource Development Act), passed by the U.S. Congress in 1974, established a national health planning program which was implemented in each state and several American territories. The intent of Congress was to integrate previously sponsored programs (Hill-Burton, Regional Medical Program, Comprehensive Health Planning), retain the best features of each, and address major national, state, and local concerns about the current planning, development, and operation of the nation's health care system. To address these concerns, the Act authorized the designation and funding of state and regional health planning agencies and set forth several functions these agencies had to perform in order to further the "achievement of equal access to quality health care at a reasonable cost."

HEALTH SYSTEMS AGENCIES

Health Systems Agencies (HSAs) were designated as local or regional bodies with the responsibility for preparing and implementing plans designed to improve the health of the residents of its health service area; to increase the acceptability, accessibility, continuity and quality of health services of the area; to restrain increases in the cost of providing health services; and, to prevent unnecessary duplication of health resources. These functions were carried out by interested consumers and providers working together to identify community and regional problems and to develop strategies and recommendations to help alleviate those problems.

HSAs were established as either private, non-profit corporations or public entities governed by boards that had to have a consumer majorities. Operational funds have been awarded through both Federal (PHS) and State (DHSS) sources. In Alaska, the Governor designated three health service areas which were each to be served by an HSA. Alaska's three HSAs are: Northern Alaska Health Resources Association, Inc. (Fairbanks), serving northern Alaska; South Central Health Planning and Development, Inc. (Anchorage), serving south central Alaska, including the Aleutian chain; and Southeast Alaska Health Systems Agency (Ketchikan), serving Alaska's panhandle.

South Central
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1135 West Eighth Avenue • Suite 1 • Anchorage, Alaska 99501
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March 7, 1983

Al Adams
Pouch V - Mail Stop 3100
Juneau, Alaska 99811

Dear Representative Adams:

At the March 5, 1983 meeting of South Central Health Planning and Development, Inc., the Board voted to direct staff to represent the attached position on the Certificate of Need repeal bill. The paper attached was originally put out by the Alaska Health Coalition, a loosely organized group made up of executive directors and presidents of the boards of the three Health Systems Agencies, president of the Municipal Health Commission, and president of the Statewide Health Coordinating Council.

The position paper points out that there is merit in the Certificate of Need program in Alaska and that problems with the existing law can be corrected by amending the law.

In reviewing the repeal bills before the House, your Committee might want to consider the Certificate of Need issue within the larger context of public expenditures for hospitals and inpatient health care services.

If you have any questions about the position paper please do not hesitate to contact me or Susan Callan at our office.

Sincerely yours,

Margaret McClure Wilson

Margaret M. Wilson
Director

MMW/cr