

ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10219 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

Subject: HB 367

Date: Fri, 15 Feb 2002 15:06:34 -0900

From: "Linda Milliken" <linda_milliken@hotmail.com>

To: Representative_Fred_Dyson@legis.state.ak.us,
Representative_Peggy_Wilson@legis.state.ak.us,
Representative_John_Coghill@legis.state.ak.us,
Representative_Gary_Stevens@legis.state.ak.us,
Representative_Vic_Kohring@legis.state.ak.us

Dear Representatives,

HB 367, "An Act relating to coverage of children and pregnant women under the medical assistance program" proves Representative Coghill's complete lack of consideration of women and children in need.

Approximately 4,000 children and 700 pregnant woman in Alaska will lose their Denali Kid Care health coverage if this legislation is passed.

It is not possible to make enough cuts in our state government to make up for the our current budget deficit. It is frightening to me that this legislation attempts to "save" the state money by eliminating health care benefits to Alaskan women and children who desparately need it.

We need a responsible fiscal plan that will bring in additional revenues for the state. It is time for the majority to muster up the courage to support such a plan.

HB 367 does not deserve to see the light of day. Please do not consider it further.

Sincerely,

Linda Milliken
PO Box 82275
Fairbanks, AK 99708

Send and receive Hotmail on your mobile device: <http://mobile.msn.com>

Public Opinion Message

Contact your nearest Legislative Information Office to send your POM
 This form must be completely filled out. You may phone, fax, or deliver your POM to any LIO.

From: Please PRINT the information below. This form must be signed by the sender.

Mr. / Ms. / Mrs.	First name NATALIE	M.I.	Last name McCULLOUGH	Jr. / Sr. / III
Group affiliation (if applicable)				Daytime telephone number
Mailing address 9320 ROY ST ANCHORAGE, AK				Zip code 99515
Residence (street) address if different from mailing address				Zip code
Email address GUSSPOTCHIAU@YAHOO.COM		Signature <i>Natalie McCullough</i>		Date 2/15/02

To: Put a ✓ in the appropriate box(es).

	House members	Senate members
H or S		
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	Committees
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<input type="checkbox"/>	<input type="checkbox"/> Majority (mjr)
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Subject: Fill out the boxes below OR enter a Subject.

HB or SB	Bill number		and check one:	<input checked="" type="checkbox"/> Support	
HB	367			<input type="checkbox"/> Oppose	OR enter a general Subject
				<input type="checkbox"/> Amend	(LIO staff may modify):

Message: Your PRINTED message cannot exceed 50 words or contain any vulgar language.

WITHOUT	DETAILED	KID	CARE	5
WOULD	BE	HAVE	NO	10
TO	CARE	FOR	MYSELF	15
MY	UNBORN	CHILD.	I	20
ALL	SERVICES	THEY	PROVIDE.	25
				30
				35

Public Opinion Message

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From: Please PRINT the information below. This form must be signed by the sender.

Mr. / Ms. / Mrs.	First name Ms. Nichole	M.I.	Last name R Encelewski	Jr. / Sr. / III
Group affiliation (if applicable)				Daytime telephone number (907) 278-4343
Mailing address 16141 E. 41st CT #4 Anchorage AK				Zip code 99508
Residence (street) address if different from mailing address Same				Zip code
Email address Nikitabear7@yahoo.com			Signature	Date 2-15-02

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Committees	House members	Senate members																																																																																																																																																																												
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Subject: Fill out the boxes below **OR** enter a Subject.

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border: 1px solid black;">HB or SB</td> <td style="width: 50%; border: 1px solid black;">Bill number</td> </tr> <tr> <td style="border: 1px solid black;">HB</td> <td style="border: 1px solid black;">367</td> </tr> </table>	HB or SB	Bill number	HB	367	and check one:	<input type="checkbox"/> Support <input checked="" type="checkbox"/> Oppose <input type="checkbox"/> Amend	OR enter a general Subject (LIO staff may modify):
HB or SB	Bill number						
HB	367						

Message: Your PRINTED message cannot exceed 50 words or contain any vulgar language.

IF	Not	For	Denali	Kidcair	5
I	would've	had	almost	or	10
over	\$100,000	in	medical	Bills	15
for	my	pregnancy	and	delivery	20
It	helped	me	out	immensely	25
					30
					35

Public Opinion Message

Contact your nearest Legislative Information Office to send your POM
This form must be completely filled out. You may phone, fax, or deliver your POM to any LIO.

From: Please PRINT the information below. This form must be signed by the sender.

Mr. / Ms. / Mrs. <input checked="" type="checkbox"/>	First name NATALIE	M.I. A	Last name MCCULLOUGH	Jr. / Sr. / III
Group affiliation (if applicable)				Daytime telephone number
Mailing address 9320 BOY ST ANCHORAGE, AK				Zip code 99515
Residence (street) address if different from mailing address				Zip code
Email address BUSSPOITCH@YAHOO.COM		Signature <i>Natalie A. McCullough</i>		Date 2/15/02

To: Put a ✓ in the appropriate box(es)

Public Opinion Message

Contact your nearest Legislative Information Office to send your POM
 This form must be completely filled out. You may phone, fax, or deliver your POM to any LIO.

From: Please PRINT the information below. This form must be signed by the sender.

Mr. / Ms. / Mrs. MR.	First name Victor	M.I. J	Last name Van Scoy	Jr. / Sr. / III II
Group affiliation (if applicable)				Daytime telephone number 274-1515 4
Mailing address 750 W 5th Ave				Zip code 99501
Residence (street) address if different from mailing address N/A				Zip code
Email address hotcaster@hotmail.com		Signature <i>Victor Van Scoy</i>		Date 2/19/02

To: Put a in the appropriate box(es).

Committees	House members	Senate members
Hors <input type="checkbox"/> Community & Regional Affairs (cra) <input type="checkbox"/> Finance (fin) <input checked="" type="checkbox"/> Health, Ed., & Social Services (hes) <input type="checkbox"/> Judiciary (jud) <input type="checkbox"/> Labor & Commerce (l&c) <input type="checkbox"/> Resources (res) <input type="checkbox"/> Rules (rts) <input type="checkbox"/> State Affairs (sta) <input type="checkbox"/> Transportation (tra) <input type="checkbox"/> Other: <input type="checkbox"/> Other:	<input type="checkbox"/> Berkowitz (ber) <input type="checkbox"/> Bunde (bun) <input type="checkbox"/> Chenault (che) <input checked="" type="checkbox"/> Cissna (cis) <input checked="" type="checkbox"/> Coghlin (cog) <input type="checkbox"/> Crawford (crf) <input type="checkbox"/> Croft (cro) <input type="checkbox"/> Davies (dav) <input checked="" type="checkbox"/> Dyson (dys) <input type="checkbox"/> Fate (fht) <input type="checkbox"/> Foster (fos) <input type="checkbox"/> Grant (gm) <input type="checkbox"/> Guess (gue) <input type="checkbox"/> Halcro (hac) <input type="checkbox"/> Harris (har) <input type="checkbox"/> Hayes (hay) <input type="checkbox"/> Hudson (hud) <input type="checkbox"/> James (jam) <input checked="" type="checkbox"/> Joule (jou) <input type="checkbox"/> Kapsner (kap)	<input type="checkbox"/> Kertula (ker) <input checked="" type="checkbox"/> Kohring (koh) <input type="checkbox"/> Kookesh (kos) <input type="checkbox"/> Kott (kot) <input type="checkbox"/> Lancaster (lnc) <input type="checkbox"/> Lassek (mas) <input type="checkbox"/> McGuire (mcg) <input type="checkbox"/> Meyer (mey) <input type="checkbox"/> Morgan (mor) <input type="checkbox"/> Moses (mos) <input type="checkbox"/> Mulder (mul) <input type="checkbox"/> Murkowski (mur) <input type="checkbox"/> Ogan (oga) <input type="checkbox"/> Porter (por) <input type="checkbox"/> Rokeberg (rok) <input type="checkbox"/> Scalzi (scl) <input checked="" type="checkbox"/> Stevens (stv) <input type="checkbox"/> Whitaker (whl) <input type="checkbox"/> Williams (wll) <input checked="" type="checkbox"/> Wilson (wts)
Caucuses <input checked="" type="checkbox"/> Anchorage (age) <input type="checkbox"/> Bush (bus) <input type="checkbox"/> Fairbanks/Interior (int) <input type="checkbox"/> Matsu (mat) <input type="checkbox"/> Majority (mjr) <input type="checkbox"/> Minority (mnr)		<input type="checkbox"/> Austerman (aus) <input type="checkbox"/> Cowdery (coy) <input type="checkbox"/> Davis (dab) <input type="checkbox"/> Donley (don) <input type="checkbox"/> Ellis (ell) <input type="checkbox"/> Elton (elt) <input type="checkbox"/> Green (gra) <input type="checkbox"/> Halford (hal) <input type="checkbox"/> Hoffman (hof) <input type="checkbox"/> Kelly (kep) <input type="checkbox"/> Leman (lem) <input type="checkbox"/> Lincoln (lin) <input type="checkbox"/> Olson (ols) <input type="checkbox"/> Phillip (phi) <input type="checkbox"/> Stevens (ste) <input type="checkbox"/> Taylor (tay) <input type="checkbox"/> Theriault (thr) <input type="checkbox"/> Torgerson (tor) <input type="checkbox"/> Ward (war) <input type="checkbox"/> Wilken (wfk)

Subject: Fill out the boxes below **OR** enter a Subject.

HB or SB HB	Bill number 367	and check one:	<input checked="" type="checkbox"/> Support <input checked="" type="checkbox"/> Oppose <input type="checkbox"/> Amend	OR enter a general Subject (LIO staff may modify):
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Message: Your PRINTED message cannot exceed 50 words or contain any vulgar language.

Dont	set	rid	of	it	5
it	good	and	helps	a	10
Lot	of	people	out		15
					20
					25
					30
					35

Public Opinion Message

Contact your nearest Legislative Information Office to send your POM
 This form must be completely filled out. You may phone, fax, or deliver your POM to any LIO.

From: Please **PRINT** the information below. This form must be signed by the sender.

Mr. / Ms. / Mrs.	First name Kenneth	M.I. G	Last name Kirkman	Jr. / Sr. / III III
Group affiliation (if applicable)				Daytime telephone number 238-2434
Mailing address 1306 West 6th apt 2				Zip code 99501
Residence (street) address if different from mailing address				Zip code
Email address			Signature Kenneth Kirkman	Date 2/19/02

To: Put a in the appropriate box(es).

	Committees	House members	Senate members
H or S			
<input type="checkbox"/>	<input type="checkbox"/> Community & Regional Affairs (cra)	<input type="checkbox"/> Berkowitz (ber)	<input type="checkbox"/> Austerman (aus)
<input type="checkbox"/>	<input type="checkbox"/> Finance (fin)	<input type="checkbox"/> Bunde (bun)	<input type="checkbox"/> Cowdery (coy)
<input checked="" type="checkbox"/>	<input type="checkbox"/> Health, Ed., & Social Services (hes)	<input type="checkbox"/> Chenault (che)	<input type="checkbox"/> Davis (dab)
<input type="checkbox"/>	<input type="checkbox"/> Judiciary (jud)	<input checked="" type="checkbox"/> Cissna (cis)	<input type="checkbox"/> Donley (don)
<input type="checkbox"/>	<input type="checkbox"/> Labor & Commerce (l&c)	<input checked="" type="checkbox"/> Coghill (cog)	<input type="checkbox"/> Ellis (ell)
<input type="checkbox"/>	<input type="checkbox"/> Resources (res)	<input type="checkbox"/> Crawford (crf)	<input type="checkbox"/> Elton (elt)
<input type="checkbox"/>	<input type="checkbox"/> Rules (rs)	<input type="checkbox"/> Croft (cro)	<input type="checkbox"/> Green (gre)
<input type="checkbox"/>	<input type="checkbox"/> State Affairs (sta)	<input type="checkbox"/> Davies (dav)	<input type="checkbox"/> Halford (hal)
<input type="checkbox"/>	<input type="checkbox"/> Transportation (tra)	<input checked="" type="checkbox"/> Dyson (dys)	<input type="checkbox"/> Hoffman (hof)
<input type="checkbox"/>	<input type="checkbox"/> Other:	<input type="checkbox"/> Fate (fht)	<input type="checkbox"/> Kelly (kep)
<input type="checkbox"/>	<input type="checkbox"/> Other:	<input type="checkbox"/> Foster (fos)	<input type="checkbox"/> Leman (lem)
		<input type="checkbox"/> Green (gm)	<input type="checkbox"/> Lincoln (lin)
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		<input type="checkbox"/> Harris (har)	<input checked="" type="checkbox"/> Philip (phi)
		<input type="checkbox"/> Hayes (hay)	<input type="checkbox"/> Rokeberg (rok)
		<input type="checkbox"/> Hudson (hud)	<input type="checkbox"/> Scatzi (scl)
		<input type="checkbox"/> James (jam)	<input checked="" type="checkbox"/> Stevens (stv)
		<input type="checkbox"/> Joule (jou)	<input type="checkbox"/> Whitaker (whi)
		<input checked="" type="checkbox"/> Kapsner (kap)	<input type="checkbox"/> Williams (wit)
			<input checked="" type="checkbox"/> Wilson (wfs)
			<input type="checkbox"/> Wiken (wik)

Subject: Fill out the boxes below **OR** enter a Subject.

HB or SB	Bill number		and check one:	<input checked="" type="checkbox"/> Support		
				<input type="checkbox"/> Oppose	OR	enter a general Subject
				<input type="checkbox"/> Amend		(LIO staff may modify):

Message: Your **PRINTED** message cannot exceed 50 words or contain any vulgar language.

I	strongly	oppose	this	bill	5
to be					10
					15
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Public Opinion Message

Contact your nearest Legislative Information Office to send your POM
 This form must be completely filled out. You may phone, fax, or deliver your POM to any LIO.

From: Please PRINT the information below. This form must be signed by the sender.

Mr. / Ms. / Mrs.	First name	M.I.	Last name	Jr. / Sr. / III
ms	Heather	L	Cordley	
Group affiliation (if applicable)				Daytime telephone number
				269061
Mailing address				Zip code
83 D Street Anch, AK				99501
Residence (street) address if different from mailing address				Zip code
Email address			Signature	Date
			Heather Cordley	

To: Put a in the appropriate box(es).

	Committees	House members	Senate members
H or S			
<input type="checkbox"/>	Community & Regional Affairs (cra)	<input type="checkbox"/> Berkowitz (ber)	<input type="checkbox"/> Austerman (aus)
<input type="checkbox"/>	Finance (fin)	<input type="checkbox"/> Bunde (bun)	<input type="checkbox"/> Cowdery (coy)
<input checked="" type="checkbox"/>	Health, Ed., & Social Services (hes)	<input type="checkbox"/> Chenault (cha)	<input type="checkbox"/> Davis (dab)
<input type="checkbox"/>	Judiciary (jud)	<input checked="" type="checkbox"/> Cissna (cis)	<input type="checkbox"/> Donlay (don)
<input type="checkbox"/>	Labor & Commerce (l&c)	<input checked="" type="checkbox"/> Coghill (cog)	<input type="checkbox"/> Elks (elt)
<input type="checkbox"/>	Resources (res)	<input type="checkbox"/> Crawford (crf)	<input type="checkbox"/> Elton (elt)
<input type="checkbox"/>	Rules (rsa)	<input type="checkbox"/> Croft (cro)	<input type="checkbox"/> Green (gre)
<input type="checkbox"/>	State Affairs (sta)	<input type="checkbox"/> Davies (dav)	<input type="checkbox"/> Halford (hal)
<input type="checkbox"/>	Transportation (tra)	<input checked="" type="checkbox"/> Dyson (dys)	<input type="checkbox"/> Hoffman (hof)
<input type="checkbox"/>	Other:	<input type="checkbox"/> Fate (fnt)	<input type="checkbox"/> Kelly (kep)
<input type="checkbox"/>	Other:	<input type="checkbox"/> Foster (fos)	<input type="checkbox"/> Leman (lem)
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		<input type="checkbox"/> James (jam)	<input type="checkbox"/> Torgerson (tor)
		<input checked="" type="checkbox"/> Joule (jou)	<input type="checkbox"/> Ward (war)
		<input type="checkbox"/> Kapsner (kap)	<input type="checkbox"/> Wilken (wk)
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		<input type="checkbox"/> Masek (mas)	
		<input type="checkbox"/> McGuire (mcg)	
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		<input type="checkbox"/> Stevens (stv)	
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Subject: Fill out the boxes below OR enter a Subject.

HB or SB	Bill number		and check one:	<input type="checkbox"/> Support	<input checked="" type="checkbox"/> Oppose	<input type="checkbox"/> Amend	OR enter a general Subject (LIO staff may modify):
AB	367						

Message: Your PRINTED message cannot exceed 50 words or contain any vulgar language.

	I think	it is	a great	5
	program	and	many people	10
	who	use it	and	15
	thankfull	for	it	20
				25
				30
				35



Alaska State Legislature

Please enter into the record my testimony to the House HES
committee name

Committee on HB 367, dated 2-14-02
bill # / subject

SEE 1 PAGE ATTACHED

Signed: CHARLES QUARRE
Testifier

SELF
Representing (optional)

36525 BRADFORD RD STERLING, AK 99672
Address

(907) 262-2115
Phone number

Additional comments on HB367 for POM to be FAXed to the members of the House Health, Education & Social Services Committee.

This Bill's efforts to reduce State expenditures are to be commended but why is it that the lowest on the totem pole are always the first to be the targets of reduction in services? The statistics developed by the Dept. of Health and Social Services and Representative Coghill's office are impressive but they do not bring to light the human suffering of those on the low end of the financial chain. This was brought out in the many personal accounts of the need for Denali Kid-Care benefits that were presented to the Committee on the teleconference of February 14, 2002. It is possible that there is some abuse of the program by individuals. By proper administration and supervision these can be reduce or eliminated.

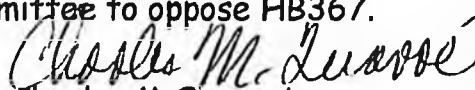
What is to happen to the number of children (3821) and pregnant women, carrying a living child, (722) who will lose coverage by enactment of HB367? Past experience has shown that they will wait until the last moment when their ailments are most serious to report to emergency services for treatment that will cost infinitely more that if taken care of in a timely fashion.

It is estimated that the State will save \$5 million by implementation of this bill but will lose \$11.9 million in federal aid. This does not seem to be a very advantageous arrangement.

Our youth are our treasure, and the future leaders of our State and Country. We are going at great lengths to insure they receive an adequate education. Insuring their health will make the education expenditures even more valuable.

It has been said that the measure of a civilized society and culture is the way in which they treat their most vulnerable members, certainly these children are vulnerable and in need of our compassion and aid.

I respectfully request the Committee to oppose HB367.


Charles M Quarre
quar@alaska.com



Alaska State Legislature

Please enter into the record my testimony to the House Health, Education and Social Services
 committee on HB 367 / Medical Assistance committee name
 dated 2/21/02
 bill/subject program coverage

I am a pregnant woman in great support of Denali Kid Care. I am employed and have some insurance coverage. However I pay into the plan for order for my husband to be covered. ^{He is a seasonal worker} If I were to exceed the medical needs beyond which ~~my~~ this plan covered, I would not be able to afford care for my self or unborn child. When this child is born, having Denali Kid care will allow this child to have medical check ups and proper care. I could not afford this otherwise. Please keep Denali Kid Care. Since I do work, ~~raising~~ lowering the income level would put me in jeopardy of losing this great support. I feel like middle income, straddling the poverty line people are constantly penalized for trying to make a decent living.

Signed: Dana Roberts
 Testifier Self.

Representing (Optional)
P.O. Box 3532, Homer, AK.
 Address
907-235-1921
 Phone No.

(H) HES HB 367

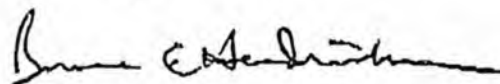
2/21/02

PROTECT AND DEFEND ALASKA'S CHILDREN:

Denali Kid Care (DKC) is a matter of life and death to many of Alaska's children. Timely application of medical therapy, psychological counseling, and psychiatric care can prevent spread of diseases, accidents, crimes, and suicide attempts, which would otherwise result in much higher costs that the State would have to pay to hospitals, prisons, and institutions. Cutting the number of Denali Kid Care recipients is saving a nickel at the cost of a dollar.

There are times when a good Republican must place childrens' health and States' responsibility and rights at a higher priority than thrifty budgeting. Our Alaskan Republican Party has a good reputation. Please protect our reputaion. Refuse to become the party that attempts to balance Alaska's budget on the backs of Alaska's neediest children.

Best regards,



Bruce Hendrickson
PO Box 1439
Homer, AK 99603
235-2748

A United Way Community Partnership



P.O. Box 141689 Anchorage, AK 99514-1689
3350 Commercial Drive, Second Floor

Phone: (907) 563-1923 Fax: (907) 563-1959
Email: probinso@childcareconnection.org

DRAFT

Resolution in Support of Funding for Denali KidCare at the Current Level 2002-4

Whereas, in 1996 more than one out of every three children 17 years old or younger in the United States were not covered by private health insurance; and

Whereas, in 1997 Congress adopted the State Child Health Insurance Program (S-CHIP), which allows states to access federal Medicaid funds to provide insurance for uninsured children in working and non-working families. Approximately 71% of the cost is from the federal government; and

Whereas, Denali KidCare, as Alaska's CHIP, began offering health care insurance coverage March 1, 1999 to uninsured Alaskan children and to pregnant Alaskan women; and

Whereas, many employers are not able to pay for dependent health care insurance due to continuously rising costs^{1,2}, nor are the employees able to afford the coverage as employers shift more or all of the costs to the employees³; and

Whereas, a family of four qualifies if their family income is less than \$44,140 per year (\$3678 per month); and

Whereas, between its inception and June 2000, over 15,000 additional Alaskan children from low-income working families have health insurance through Denali KidCare⁴; and

Whereas, the availability of Denali KidCare has allowed parents formerly on welfare to obtain paying jobs without fear of losing coverage for their children; and

Whereas, insured children are more likely to receive well-baby/well-child care, adequate and timely immunizations, and have health care problems discovered and treated earlier; and

¹ Alaskan businesses report a 10% increase in premium rates from 2001 to 2002. Credit Suisse First Boston, *2002 Benefit Manager Survey*, 15 January 2002, 34.

² The percentage of Anchorage employers paying the full cost of benefits for their employees has decreased by over 50% in the last 8 years for businesses with more than 50 employees, to about 20%. Catherine Schumacher, *Anchorage Access to Health Care Coalition Health Insurance Benefits Survey*, September 2001.

³ At least 30% of surveyed Anchorage businesses pay none of the dependent health insurance premium costs. The average additional dependent premiums cost \$340 per month. Ibid.

⁴ Alaska Department of Health and Social Services, *Welfare Reform Status Report 2000*, available from www.hss.state.alaska.us/publications/3annreport.pdf; accessed 20 September 2001.

Whereas, for every dollar spent on prenatal care, more than three are saved in lower costs for treating the consequences of low birth weight and prematurity⁵; and

Whereas, early and consistent prenatal care decreases the risk of death or disability for both the mother and child;

Whereas, uninsured Alaskans are more likely to use expensive emergency room services and to have more serious health problems once they do get treatment; and

Whereas, non-profit health care providers have experienced a continual rise in uncompensated care. For example, Anchorage Neighborhood Health Center has experienced an increase of 43% from 1997-2000 (\$646,000)⁶; and

Whereas, the current cost per year to the State of Alaska for Denali KidCare is \$552 per child and \$4580 per pregnant woman and newborn child until 2 months old; and

Whereas, if the change in eligibility from 200% of Federal Poverty Level to 150% goes into effect, it is estimated that 3821 children and 722 pregnant women and newborns will lose health care coverage; and

Whereas, the State of Alaska will save approximately \$5 million dollars, but will give up almost \$12 million in matching Federal funds;

Whereas, these 4543 Alaskan will increase the pressure on health providers for uncompensated care; and

Whereas, absences from school and undiagnosed or untreated hearing, vision, dental, or health problems negatively affect the children's ability to learn and increase the schools' costs for remediation;

Therefore, be it resolved, that the Success By 6 Governance Board strongly urges the Alaska Legislature to continue to accept Alaskans with up to 200% of the Federal Poverty Rate for the Denali KidCare Program.

Approved via email distribution by the Success By 6 Governance Board on February 20, 2002.

Ernie Hall

Ernie Hall, Chair

⁵ Center for Health Economics Research, *Access To Health Care*, 1993.

⁶ Anchorage Neighborhood Health Center, *Newsletter June/July 2001*, page 2.

Subject: HSB367- Please vote down!

Date: Wed, 20 Feb 2002 21:10:24 -0500 (EST)

From: "" <kkerlin1@excite.com>

To: Representative_Peggy_Wilson@legis.state.ak.us,
Representative_Fred_Dyson@legis.state.ak.us, Representative_John_Coghill@legis.state.ak.us,
Representative_Vic_Kohring@legis.state.ak.us,
Representative_Gary_Stevens@legis.state.ak.us,
Representative_Sharon_Cissna@legis.state.ak.us,
Representative_Reggie_Joule@legis.state.ak.us

Dear HESS committee members,

I am writing to express my concern over the HB367 proposal to make cuts in the Denali KidCare budget. The number of children/families this would negatively effect is very significant and Alaska can not afford to have so many of it's children not having their basic health and safety needs met. So many of us are working diligently to assist children and families to develop in positive ways. This can not be done if children are unhealthy and can't get the services they need.

Nationwide, the amount of mental health problems among even our youngest children is at an all time high. The agency I work for recently surveyed child care providers in Alaska and found that their primary training and consultation needs revolve around serving children who experience emotional and behavioral health problems. If these children and their families can't have access to basic mental health services at an early age, they are very likely to develop permanent mental health illnesses as adults that often cause a much greater burden upon society than dollars spent on preventive services, such as DKC.

I strongly urge you to vote this bill down and not approve its proposal. Thank you for considering my request.

Sincerely,

Kimberly Kerlin, MA
Mental Health Consultant
1540 Russian Jack Dr. #13
Anchorage, AK 99508
(907) 563-1973

Subject: HB 367

Date: Wed, 20 Feb 2002 16:57:16 -0900

From: "Peggy Robinson" <probinso@childcareconnection.org>

To: <Representative_Sharon_Cissna@legis.state.ak.us>,
 <Representative_John_Coghill@legis.state.ak.us>,
 <Representative_Fred_Dyson@legis.state.ak.us>,
 <Representative_Reggie_Joule@legis.state.ak.us>,
 <Representative_Vic_Kohring@legis.state.ak.us>,
 <Representative_Gary_Stevens@legis.state.ak.us>,
 <Representative_Peggy_Wilson@legis.state.ak.us>


Dear Members of the House Health, Education, & Social Services Committee:

Attached is a resolution by the Success By 6 Governance Board in support of keeping the 200% of Federal Poverty Level threshold for income eligibility for Denali KidCare. Due to your committee considering HB 367 tomorrow, our chair, Ernie Hall, authorized me to send you this email version - a hard copy one will be arriving in the mail later.

Please keep this bill in committee - the prevention and early detection of health and wellness problems in children pays for itself many times over during their lifetime. Families with incomes up to 200% of the Federal Poverty Level do not have enough discretionary income to pay for dependent health insurance coverage.

Thank you for your work for children.

Peggy Robinson, Director
 Success By 6 Initiative
 P.O. Box 141689
 Anchorage, AK 99514-1689
 (907)563-1923 phone (907)563-1959 fax
 probinso@childcareconnection.org

 Resolution to keep 200% Income Level.doc	<p>Name: Resolution to keep 200% Income Level.doc Type: WINWORD File (application/msword) Encoding: base64 Download Status: Not downloaded with message</p>
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Subject: HB 367

Date: Wed, 20 Feb 2002 14:17:12 -0900

From: "Jonalyn Najera" <lillyloopy@gci.net>

To: <Representative_Fred_Dyson@legis.state.ak.us>

To whom it may concern:

I testified on Feb. 14th against HB367. If this bill was approved it would devastate my family. My 8 year old daughter is diagnosed with a mental illness, early onset bipolar disorder. Without Denali Kid Care I would not be able to treat her. Her mental health costs alone last year were in excess of at least \$25,000, as a conservative estimate. This does not include the costs of her pediatrician, her eye problems, or the dentist. I also have another child that needs her regular child visits to the doctor.

We are a working family, and also in the Naval Reserve. We make approximately \$42,000 a year before our dividends. We do NOT live an extravagant lifestyle in the least bit...we can barely afford groceries on a regular basis. We struggle to buy clothes for school each year, and doing ANY sports activities or entertainment things for our children DO NOT happen, because we cannot afford them.

My husband receives insurance for HIMSELF only, through his employer. For myself and our children to get insurance it would be from \$800-\$1000 a month, PLUS co-pays and deductibles. There would be no possible way for us to afford any of this. Even in the event that we did have insurance, and could afford the co-pay's and deductibles.....insurance companies really limit mental health issues. Most insurance companies limit your mental health visits from 8-20 visits a year. My daughter exceeds this in one month.

Having medical/mental health insurance for my daughter is a MUST HAVE thing. The suicide rate of bipolar kids is 25%! My daughter, at the age of 7 started being suicidal. Without the proper medications and therapy, the possibility of her taking her own life is TOO high to risk.

PLEASE MAKE THE RIGHT DECISION AND OPPOSE THIS BILL!! YOU COULD BE SAVING MY DAUGHTER'S LIFE AS WELL AS MANY OTHER SICK CHILDREN!!!

Thank you for your time,

Jonalyn Najera

349-1304

lillyloopy@gci.net

Subject: HB 367: Medical Assistance Program Coverage

Date: Wed, 20 Feb 2002 11:38:29 -0900

From: "Lewis, Sarah" <slewis@kumin.alaska.com>

To: <representative_Fred_Dyson@legis.state.ak.us>

Dear Representative Dyson,

as a mother and a member of Alaska's professional community, as well as a person highly interested in positive social policy for Alaska's children:

I urge you not to pass HB 367 out of the House HES committee. Please, keep Denali KidCare eligibility intact at 200% of the Federal poverty level.

Routine prenatal, infant, and childhood medical care are crucial for the health of Alaska's children. I understand from contacts in Juneau that you are truly concerned about the welfare of children, and I believe them. I also understand your concern about Alaska's fiscal difficulties, as I share them. Attempting to save the 5 million dollars spent on health care for children is an inefficient and short-sighted way to alleviate budget shortfalls. We save 5 million, but lose 11.9 million in Federal dollars coming into the state's economy. Further, we end up spending more than 5 million dollars when working families, unable to afford sky-rocketing insurance premiums and deductibles, are forced to apply to the state for assistance (to pay for the medical care or for the other necessities neglected in order to pay for medical costs). Emergency medical care will continue to be necessary (even more so as routine care is eliminated due to cost constraints) even if eligibility for Denali KidCare is reduced. It will not go away, and will end up on the State's tab, with no Federal assistance in most cases.

The passage of this bill would hurt two groups of Alaskan citizens whom I know you support: Children and working families. It has been shown that prenatal care is the single most cost-effective health care expenditure. Children with health care coverage are more likely to receive well-baby/well-child care, adequate immunizations, and have health care problems discovered early. It does not make fiscal, public health, or social welfare sense to reduce the coverage of Denali KidCare. It is a program all Alaskans should be proud of and support at the level it is presently funded.

Thank you for your consideration,

Sarah R-P. Lewis, AIA, CDT

1551 Sunrise Drive
Anchorage, AK 99508
907-274-8844

Subject: Fw: Voice from the front line

Date: Wed, 20 Feb 2002 23:45:21 -0900

From: "Bill and Ruthe Schoder-Ehri" <lovenest@ptialaska.net>

To: <Representative_Fred_Dyson@legis.state.ak.us>

CC: <Representative_John_Coghill@legis.state.ak.us>,
<Representative_Vic_Kohring@legis.state.ak.us>,
<Representative_Gary_Stevens@legis.state.ak.us>,
<Representative_Sharon_Cissna@legis.state.ak.us>,
<Representative_Reggie_Joule@legis.state.ak.us>

Dear Representative,

Your work is so important, and so is mine.

I am a nurse working in the villages around the Chugach region. I've been a public health nurse in urban King County (Seattle area) and a maternal-child health nurse for over 25 years. I feel so proud of Alaska's Denali Kid Care program since returning to Alaska five years ago. I fully support all the "up front" dollars that are spent by Alaskans to provide quality prenatal care, safe deliveries and early newborn care. We are making a big difference in the health of families. Hard to prove; easy to forget.

It seems short sighted to even **propose** cutting this program.

PLEASE please consider the implications in a reduction of so many federal dollars and the impact on individuals and babies that need attention in order to prevent more problems in the future.

I urge you to reject any cuts to Denali Kid Care recipients!

From the front lines, for the little ones and the women who are low and middle income, I ask you to care. Keep the current funding levels--our state can afford the cost of prevention.

Thanks!

Ruthe Schoder-Ehri, R.N., PHN
480 Grubstake Avenue
Homer, Alaska 99603
(907)235-1504



Alaska's Federal Poverty Level (FPL) Eligibility Guidelines

Income standards effective April 1, 2001

NOTE An unborn child of a pregnant woman is counted in the family size for pregnant woman coverage.

Family Size	Annual Income Kids with other health insurance	Monthly Income Kids with other health insurance	Annual Income Kids with no insurance Pregnant women with or without health insurance	Monthly Income Kids with no insurance Pregnant women with or without health insurance
	150% FPL	150% FPL	200% FPL	200% FPL
1	\$16,095	\$1,342	\$21,460	\$1,789
2	\$21,765	\$1,814	\$29,020	\$2,419
3	\$27,435	\$2,287	\$36,580	\$3,049
4	\$33,105	\$2,759	\$44,140	\$3,679
5	\$38,775	\$3,232	\$51,700	\$4,309
6	\$44,445	\$3,704	\$59,260	\$4,939
7	\$50,115	\$4,177	\$66,820	\$5,569
8	\$55,785	\$4,649	\$74,380	\$6,199
Each additional	\$ 5,670	\$ 473	\$ 7,560	\$ 630

Key Points

- ◆ Income figures above are gross income (before taxes are taken out).
- ◆ Income eligibility is generally based on income for the 30 days prior to the processing of the application.
- ◆ A standard deduction per month for work expense and a standard deduction per month for dependent care expense may apply.
- ◆ Permanent Fund Dividends are not counted as income.
- ◆ Anyone can apply for her/himself or on behalf of a child or teen.
- ◆ Income eligibility is determined based on biological or adoptive parent income.
- ◆ Children with other insurance may still be eligible.

February 13, 2002

Dear Rep. Coghill

I have just been informed of a proposition that is trying to be passed that would eliminate Denali Kid Care. I just want to share a little story of how beneficial Denali Kid Care to our family and why this would be a devastation if this bill passed.

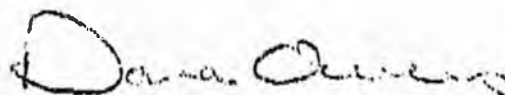
We moved to Alaska in '99, at that time we did not have health insurance. We had 4-year-old daughter and 1-½ year old twins. We could not afford the \$600+ a month for insurance we would have to pay through COBRA to continue insurance. We qualified for insurance for our children through Denali Kid Care.

Three months after we arrived in Alaska, it was discovered that our oldest daughter Darci, who has Down Syndrome, would need open-heart surgery to correct a birth defect in her heart. Since that type of surgery cannot be performed here in Alaska, we had to go to Portland for the Surgery. I cannot praise enough the quick – hassle free response that we received from Denali Kid Care. Darci had surgery, came through it just fine and is now a healthy 6 ½ year old going to 1st grade. Darci continues to have multiple health care concerns that are associated with Down Syndrome, but I feel like we are a success story.

We now have insurance with my employer and are getting back on our feet. But, you can imagine the expense we would have had to undergo for such procedures and I do not feel we would be where we are today without the assistance of Denali Kid Care.

This is just one of the stories that I have about the benefits of Denali Kid Care, with a family of 3 little girls I have many. But, please understand, that families like my own, that just need a little help to get back on their feet would probably suffer the most from this bill passing.

Sincerely, Dana Owens.



STATE OF ALASKA

DEPARTMENT OF HEALTH & SOCIAL SERVICES

MEDICAL CARE ADVISORY COMMITTEE

TONY KNOWLES, GOVERNOR

P.O. BOX 110660
JUNEAU, ALASKA 99811-0660
PHONE: (907) 465-3355
FAX: (907) 465-2204

February 12, 2002

The Honorable Fred Dyson
Alaska State Legislature
Capitol Room 104
Juneau, AK 99801

Dear Representative Dyson,

On behalf of the Medical Care Advisory Committee, I would like to express the committee's concern regarding House Bill 367. Required by federal law, the Alaska Medical Care Advisory Committee is responsible for advising the State's Medicaid agency on policy and program changes to the Medicaid program. The committee members include health care consumers and providers from across the state of Alaska.

The Medical Care Advisory Committee has had the opportunity to provide input to the Department of Health and Social Services on the Denali KidCare program throughout its development. We have heard from consumers and providers about their experiences with the Denali KidCare program. From our review, we learned that the program has been overwhelmingly successful in reaching needy families and has contributed immensely to the stability of these families. We also learned that parents were able to stay employed even if their children got ill because their children had health care coverage through the Denali KidCare program. These families feel empowered that they can both maintain employment and provide the right care for their children.

From the beginning, the Medical Care Advisory Committee supported the development of Denali KidCare program for a number of reasons. Numerous studies have documented that the percentage of children without health insurance has grown rapidly in recent years. Contributing significantly to the declining trend in health insurance is the decline in employer financial support for health care coverage for their employee's dependents. Families who meet the income eligibility guidelines for Denali KidCare often do not have the option of an employer financed health insurance plan for their dependents, and even if they do, they can not afford to pay their share of the health care premiums, deductibles, and copayments. The Medical Care Advisory Committee knows that children without health care coverage are six times more likely to go without needed medical care, five times more likely to use the hospital emergency room as a regular source of care, and four times more likely to have necessary care delayed. It is important to a child's

development that they receive appropriate medical care. If a child develops a chronic health problem, studies have shown that it can affect that child's health and well being for decades to come and children, especially young children, should receive annual doctor visits to monitor their growth and development. Children without health care coverage are also more likely to be missing some of their immunizations.

For these reasons, the Medical Care Advisory Committee strongly supports the Denali KidCare program and urges the Legislature to maintain the current eligibility for the program.

Sincerely,



Patti Hong, RN
Chair

Medical Care Advisory Committee members:

David Alexander, MD, Anchorage
Sam "Lavada" Bush, Fairbanks
Jim Culley, Valdez
Marie Darlin, Juneau
Kathy Dillard, Kodiak
Gary Givens, R.Ph., Anchorage
Angela Gonzalez, Anchorage

Patti Hong, RN, Anchorage
Greg Johnson, DDS, Fairbanks
Brenda Knapp, Juneau
Marilyn Mories, Palmer
Karen Pearson, Juneau

cc: House Health, Education, and Social Services Committee, Alaska State
Legislature
Governor Tony Knowles
Commissioner Jay Livey

COVENANT HOUSE ALASKA

Speaker: Anthony M. Lombardo
Director of Advocacy

Date: 02-14-2002

Re: Testimony on HB 367, House HES committee

Covenant House Alaska has secured information from the administrators of Denali Kidcare regarding the specific effect of a rollback of the coverage level from 200% to 150% of poverty level as proposed ON OUR SPECIFIC CLIENT POPULATION, NAMELY TEENS 13-19 YEARS OLD.

The information received indicates that 3316 teenagers statewide will lose their coverage if the rollback is introduced. Covenant House Alaska champions better health and living conditions for all teens, but especially for homeless and at risk kids. Removing health coverage availability from *uninsured, working* single parent and moderately low income families will do nothing to help our kids in Alaska and will only worsen the situation of the kids at Covenant House. For this reason alone, Covenant House Alaska opposes the rollback.

In addition, there has been a lot of discussion regarding the math of this program. I understand the state statistics to be that we pay 5 million dollars of state funds to receive 12 million dollars of federal funds.

Apparently, those funds cover 26,935 enrollees of which about (40%)10,457 are Alaska Natives. We are reimbursed for their participation 100% and the Native Health Community apparently derives other benefits by participating in the program.

I may NOT understand the math, But I think THAT MEANS APPROXIMATELY 40% OF OUR 5 MILLION DOLLARS COMES BACK TO THE STATE, DUE TO THE NUMBER OF ALASKA NATIVE PARTICIPANTS.

SO THEN, IT SEEMS WE ARE REALLY ONLY SPENDING ABOUT 3 MILLION DOLLARS TO GET 12 MILLION DOLLARS OF FEDERAL INCOME.

THAT'S A 4X RETURN ON OUR DOLLAR IN CAPITAL, available for health care in this state. THAT'S QUITE AN ASSET. I wish I could find a mutual fund that would do that. AND WE ARE INSURING 26935 ALASKANS. Not exactly your wasteful government program.

We believe dis-investing in such a successful asset is a bad idea. And personally, if you would like to dispose of such an income generating asset, I'd like to bid at the auction.

Thank you.

March 1, 2002

House HESS Committee

Representative Fred Dyson, Chair
Representative Reggie Joule
Representative Fred Dyson
Representative Peggy Wilson
Representative John_Coghill
Representative Gary_Stevens
Representative Vic_Kohring
Representative Sharon_Cissna

Dear Committee Members:

I write to voice my objection to the current HB 367, which changes the qualification provisions of the "Denali Kid Care Program".

Essentially, the qualification level required of different locations in Alaska are not addressed in the change proposed in HB 367. Currently, a family of four in need of assistance would qualify for the Denali Kid Care program. Both an Anchorage and Bush Alaska family would qualify under the existing rules. In the proposed rules for qualification, where the poverty level is moved to 1.5 times the federal poverty level, the Anchorage family still qualifies but the bush family would not qualify for the assistance.

Please see the attached spreadsheet that shows this anomaly.

There is no integrity in poverty level changes while a regional anomaly exists in the system.

Thank you for your time.

Eben Hopson Jr.
Arctic Slope Native Association, Ltd.

HB

402



Health, Education, and Social Services Committee
Alaska State Legislature
House of Representatives

HB 402 "AN ACT RELATING TO WELFARE REFORM"
SPONSOR STATEMENT

While the Department of Public Assistance has made strides in the application of welfare reform, lessons have been learned, and insight has been gained, that led us to propose a tune-up of public assistance.

The intent of HB 402 is to align department program operations with the work-first philosophy that has been held up by all of us as the goal. One of the key premises of this philosophy is that the labor market is the best test of an individual's employability. Another is that all individuals are capable of moving themselves and their families toward self-sufficiency. A third is that "real job" experience is the best way to specifically identify training needs.

HB 402 has made changes that in general terms:

- Implement a broader and more responsive diversion process to assist families to avoid dependency on cash benefits;
- Strengthen the "up-front message" to clients that public assistance is as much about employment as it is about providing cash benefits;
- Provide more consistent guidance with regard to assessment, emphasizing the utilization of the labor market as the best test of employability and a family strength-based approach versus an approach that emphasizes pre-determining family barriers;
- Implement a more complete subsidized wage program and expanding community service for those unable to obtain unsubsidized employment.

A M E N D M E N T

OFFERED IN THE HOUSE
TO: HB 402

BY REPRESENTATIVE DYSON

1 Page 19, line 31, following "(1)":

2 Insert "beginning on the date the department makes a finding that the family is
3 not in compliance under this subsection,"

4

5 Page 20, line 9, following "(2)":

6 Insert "beginning five months after the date the department made the finding that
7 the family was not in compliance under this subsection,"

8

9 Page 20, line 20, following "(3)":

10 Insert "beginning nine months after the date the department made the finding
11 that the family was not in compliance under this subsection,"

FISCAL NOTE

**STATE OF ALASKA
2002 LEGISLATIVE SESSION**

Fiscal Note Number: _____
 Bill Version: HB 402
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Health & Social Services
 Title: RELATING TO THE ALASKA TEMPORARY ASSISTANCE PROGRAM BRU: Public Assistance
 Component: ATAP
 Sponsor: HOUSE (HES)
 Requestor: HOUSE (HES) Component Number: 220

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES (0)						
---------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2002) cost: _____

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

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

Although this proposed legislation may allow more than 20% of the eligible ATAP caseload to receive benefits beyond 60 months, there are no projected financial impacts. The ATAP program is funded in part by the federal TANF block grant which does not vary regardless of the number of families served. Also, federal law requires the State to contribute a fixed amount of state funds toward the program, called maintenance of effort (MOE). Additionally, the provision that will allow the Department to offer transitional supportive services to clients no longer receiving a cash benefit will result in more families remaining off the program, thus reducing costs in the Temporary Assistance benefits component.

Prepared by: Jim Nordlund Phone 465-5835
 Division: Public Assistance Date/Time 02/13/2002
 Approved by: Elmer A. Lindstrom, Deputy Commissioner Date 02/14/2002
 Agency: Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

HB

407

(File 1)

ALASKA STATE HOUSE OF REPRESENTATIVES

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(907)-456-5081
Fax# (907)-456-8245




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

REPRESENTATIVE JOHN COGHILL

Memorandum

Date: March 21, 2002

To: Terri Lauterbach, Leg Legal

From: Rynnieva W. Moss, Legislative Aide 

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

Representative Coghill would like a CS with the following changes:

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

ALASKA STATE HOUSE OF REPRESENTATIVES

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Fax# (907)-456-8245



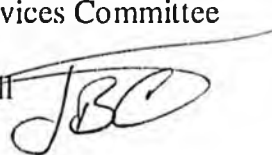
Session Contact:
(907)-465-3719
FAX# (907)-465-3258
State Capitol
Room 102

REPRESENTATIVE JOHN COGHILL

Memorandum

Date: March 21, 2002.

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

From: Representative John Coghill 

Re: HB 407 CON's

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

Thank you for your consideration.

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

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

Revision Date/Time (Note if correction): _____ Dept. Affected: Health & Social Services
 Title: RELATING TO CERTIFICATES OF NEED BRU: Medical Assistance
 Component: Medicaid Services

Sponsor: COGHILL
 Requestor: HOUSE (CRA) Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

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

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

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES (0)						
---------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2002) cost: _____

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

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

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

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

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

For distribution information, call the Governor's Legislative Office

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

BILL NO. HB 407

ANALYSIS CONTINUATION

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

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

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

Nursing Home Beds:

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

Psych Beds:

Anchorage	Providence	26 Beds	\$ 1,584.00	\$ 8,845,848
Mat-Su	North Star	18 Beds	\$ 525.00	\$ 4,234,913

Total		165 NH; 44 Psych		\$ 30,223,733
-------	--	------------------	--	---------------

ALASKA STATE HOUSE OF REPRESENTATIVES

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Session Contact:
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State Capitol
Room 102

REPRESENTATIVE JOHN COGHILL

HB 407 Certificate of Need *Sponsor Statement*

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

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

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

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

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

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

WHAT IS THE RIGHT POPULATION NUMBER?

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

ORGANIZED BOROUGH POPULATIONS

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

THE
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Statement of Revenues and Expenses
Providence Alaska Medical Cntr

	1998	1999	2000	2001	2002	2003	2004
REVENUES							
Gross Patient Revenue							
Inpatient Gross Revenue	\$ 238,536	\$ 254,306	\$ 269,044	\$ 283,807	\$ 301,159	\$ 328,486	\$ 354,653
Outpatient Gross Revenue	101,579	109,508	129,039	141,935	156,147	179,789	207,083
Total Gross Patient Revenue	340,115	363,814	398,083	425,743	457,307	508,274	561,736
Contractual Allowances							
Medicare	39,036	51,463	60,299	65,791	71,729	85,369	96,892
Medicaid	31,622	41,386	48,100	52,266	56,771	64,436	73,086
Commercial	26,118	30,035	37,347	43,092	49,466	55,749	64,672
Other Contractuals	8,105	8,191	10,802	12,125	13,578	15,544	17,787
Charity	11,910	11,267	14,061	15,093	16,207	18,007	19,958
Total Contractual Allowances	116,791	142,342	170,609	188,367	207,752	239,105	272,386
Net Patient Revenues	223,324	221,472	227,474	237,376	249,554	269,169	289,340
Other Operating Revenues	11,743	8,774	9,298	9,577	9,864	10,160	10,465
Net Revenues	\$ 235,067	\$ 230,246	\$ 236,772	\$ 246,953	\$ 259,418	\$ 279,329	\$ 299,805
EXPENSES							
Expenses							
Salaries and Wages	\$ 87,956	\$ 89,938	\$ 96,073	\$ 100,255	\$ 105,631	\$ 112,881	\$ 120,530
Benefits	17,914	19,518	21,270	22,195	23,386	24,991	26,684
Supplies	33,704	34,276	36,347	38,424	40,623	43,917	47,413
Professional Fees	12,030	5,042	4,035	4,075	4,116	4,240	4,367
Purchased Services	25,858	29,459	23,650	24,470	25,320	27,215	29,220
Purchased Healthcare	-	-	-	-	-	-	-
Interest	2,435	2,536	2,197	1,887	1,555	1,235	915
Depreciation/Amortization	14,316	16,367	16,422	18,232	19,639	21,875	24,039
Bad Debt	9,733	12,545	11,334	12,168	13,067	14,521	16,097
Other Expenses	8,895	7,534	8,091	8,334	8,584	9,871	10,168
Total Expenses	\$ 212,841	\$ 217,215	\$ 219,418	\$ 230,040	\$ 241,921	\$ 260,746	\$ 279,433
Net Operating Income	\$ 22,226	\$ 13,031	\$ 17,354	\$ 16,913	\$ 17,497	\$ 18,583	\$ 20,371
Non-Operating Rev/Exp.	10,097	5,891	11,149	10,925	7,672	8,064	9,348
Net Income Before Taxes	32,323	18,922	28,503	27,837	25,170	28,647	29,719
Taxes	-	-	-	-	-	-	-
Excess of Revenues Over Expenses	\$ 32,323	\$ 18,922	\$ 28,503	\$ 27,837	\$ 25,170	\$ 26,647	\$ 29,719

CERTIFICATES OF NEED: A BAD IDEA WHOSE TIME HAS PASSED

BY PETER DOHERTY



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

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

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

linger in the states.

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

Its History

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

will do," providers nationwide responded by offering ever-increasing levels of care and by expanding their facilities.

As the problem of increasing costs deepened and began to be labeled a crisis, policymakers in the state capitals and in Washington, D.C., scrambled to develop some solution that would control costs yet not appear to impact health care entitlement programs. Much debate and many studies were produced suggesting one course or another, but the plan that went the furthest was called certificates of need. It was a classic bureaucratic rationing and allocation

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

scheme and after being endorsed by the American Hospital Association in 1968, this plan began to gain acceptance. In 1970, New York was the first to adopt it as law,² and once part of the law in that bellwether state, the concept spread. In 1974, the federal government embraced the idea and language was added to Section XV of the Public Health Services Act that provided "incentives" for the states to enact such a program.³

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

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

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

Its Objectives

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

- Ensure the presence of high-quality and appropriately distributed services; these would provide equal access for consumers and would allow health care providers access to sufficient manpower.
- Encourage health care facilities

and providers to develop long-range operational and capacity plans based on local community health care needs.

- Require considerations of personnel and financial feasibility as well as need in the development of the long-range plans.
- Encourage the development of affordable and accessible health services to all areas of a state.
- Encourage the consideration of more cost-effective strategies through mandating a thorough review of alternative services.
- Promote the sharing of services between facilities and providers, especially in rural areas, where operational and administrative costs could threaten facility survival.
- Offer the public a forum for input regarding needs and desires prior to establishing or expanding health care facilities and services.⁶

Its Results

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

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

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

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

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

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

First change. The first change was that, gradually, both private insurers and government began to realize that the retrospective cost reimbursement plan was both inefficient and wasteful. They looked for a new model and what emerged was "prospective reimbursement," which, in part, we know today as diagnostic related groups (DRGs). These, in

turn, helped launch the era of managed care. Under prospective reimbursement, a set sum is paid to a provider based on a given condition regardless of the number of tests or procedures. It is a plan that puts a premium on efficiency of treatment in its reward structure rather than the quantity of treatment.⁹

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

Changes

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

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

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

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

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

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

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

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

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

The lobbyists, the large well-established providers and provider groups have little of the public's interest in mind. They have their own interests in mind. Proof of this can be found in those states where the program has been dropped. A study by Christopher Conover and Frank Sloan of Duke University, which examined the experiences of states that had dropped CON re-

quirements, found that no ill effects resulted. In fact, the opposite was true. When deregulation went into effect, per capita health care spending dropped and the quality and availability of service rose, thus

providing a benefit to consumers. By contrast, they found that in those states that continued to require CONs, the effect of the regulations on per capita spending was not significant, nor did it work to increase availability or quality. Hence, there was little or no benefit to consumers. What was significant in those states retaining CONs, though, was the effective stifling of compe-

dition and the raising of existing providers' profits.¹⁶

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

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

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

Endnotes

- ¹Cook, David A. Testimony before State of Georgia Joint House and Senate Health Committee, September 2, 1997.
- ²Blaufeux, Peter. *The Certificate of Need Process*. New York: Peter Blaufeux AIA Architects, 1999.
- ³McGinley, Patrick John. "Beyond Health Care Reform: Reconsidering Certificates of Need Laws in a Managed Competition System." Tallahassee, Fla.: *Florida State University Law Review*, 1995.
- ⁴Ibid.
- ⁵Cauchi, Dick. *Certificate of Need Laws: A State Legislative Survey*. Denver, Colo.: National Council of State Legislatures, 1999.
- ⁶State of Montana. *Certificate of Need Program Overview*. Helena, Mont.: Health Policy and Services Division, Montana Department of Public Health and Human Services, 1999.
- ⁷Ibid.
- ⁸Brown, Lawrence D. "Common Sense Meets Implementation: Certificate of Need Regulation in the States." *Journal of Health Politics, Policy and Law*, No. 8, 1983.
- ⁹Ibid.
- ¹⁰Ibid.
- ¹¹Ibid.
- ¹²Ibid.
- ¹³Kaplan, Mark E. "An Economic Analysis of Florida's Hospital Certificate of Need Program and Recommendations for Change." Tallahassee, Fla.: *Florida State University Law Review*, 1991.
- ¹⁴Havighurst, Clark C. "Regulation of Health Facilities and Services by 'Certificate of Need.'" Charlottesville, Va.: *University of Virginia Law Review*, 1973.



January/February 1996: Health Care

Ending the CON Game

by Michael D Tanner

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

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

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

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

1) Administrative costs

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

2) Lack of competition

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

3) Shortages

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

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

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

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

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

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

September 2, 1997

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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INTELIVIEW UNRELEASED

ALASKA STATE HOUSE OF REPRESENTATIVES

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Room 102

REPRESENTATIVE JOHN COGHILL

HB 407 Certificate of Need *Sponsor Statement*

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

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

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

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

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

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

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REPRESENTATIVE JOHN CUGHILL

CSHB 407(HSS) Sectional

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

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

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

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

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

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

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

Sections 6

Thru 10. Technical changes required under Section 5.

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

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

Section 13. Has an immediate effective date.

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

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

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

22-LS1389F
Lauterbach
3/21/02

CS FOR HOUSE BILL NO. 407()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SECOND LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

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

A BILL

FOR AN ACT ENTITLED

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

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

4 * Section 1. AS 18.07.031(a) is amended to read:

5 (a) Except as provided in (c) of this section, a person may not make an
6 expenditure of \$1,000,000 or more for any of the following unless authorized under
7 the terms of a certificate of need issued by the department:

8 (1) construction of a skilled nursing [HEALTH CARE] facility or
9 psychiatric hospital;

10 (2) alteration of the bed capacity of a skilled nursing facility or
11 psychiatric hospital or addition of nursing beds or psychiatric beds to a health
12 care facility; [OR]

13 (3) addition of a category of health services provided by a skilled
14 nursing facility or psychiatric hospital; or

1 (4) with respect to facilities and beds that are not subject to (1) -
2 (3) of this subsection, construction of a health care facility, alteration of the bed
3 capacity of a health care facility, or addition of a category of health services
4 provided by a health care facility, if the health care facility is located in the
5 unorganized borough or in an organized borough with a population of less than
6 55,000 at the time of commencement of activities, according to the latest reliable
7 data approved by the Department of Community and Economic Development.

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

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

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

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

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

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

1 AS 18.07.071 the department shall hold a public hearing within a reasonable time
2 after determining that an application under AS 18.07.035 is complete. By regulation,
3 the department shall establish

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

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

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

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

12 **Sec. 18.07.043. Standard of review for applications for certificates of need**
13 **and applications to modify certificates of need [RELATING TO NURSING**
14 **HOMES AND NURSING HOME BEDS].** (a) The department shall develop
15 review standards for an application for a certificate of need, or for a modification of a
16 certificate of need, issued under this chapter [FOR A HEALTH CARE FACILITY
17 THAT IS A NURSING HOME OR HAS NURSING HOME BEDS].

18 (b) **When determining whether to approve an application for a new**
19 **certificate of need or to modify an existing certificate of need [IN DEVELOPING**
20 **THE REVIEW STANDARDS UNDER (a) OF THIS SECTION],** the department
21 shall consider whether

22 (1) a public process and existing appropriate statewide, regional, and
23 local plans were included in planning and designing the project [ADDITIONAL
24 NURSING HOME BEDS OR THE HEALTH CARE FACILITY];

25 (2) the project will meet [ADDITIONAL NURSING HOME BEDS
26 OR THE HEALTH CARE FACILITY MEETS] minimum required use rates for the
27 proposed services without causing the [NEW NURSING BEDS, AND THE
28 EFFECT ON] use rates for existing providers of the services to fall below minimum
29 required use rates [NURSING HOME BEDS];

30 (3) the project [ADDITIONAL NURSING HOME BEDS OR THE
31 HEALTH CARE FACILITY] demonstrates consideration of the community, regional,

1 and statewide needs [FOR NEW NURSING HOME BEDS];

2 (4) the project [ADDITIONAL NURSING HOME BEDS OR THE
3 HEALTH CARE FACILITY] meets the minimum standards of the department that
4 are designed [NUMBER OF NEW NURSING BEDS THAT SHOULD BE
5 REQUIRED IN A FACILITY] to ensure efficiency and economies of scale;

6 (5) the project [ADDITIONAL NURSING HOME BEDS OR THE
7 HEALTH CARE FACILITY] demonstrates the proposed service will provide a
8 quality of care equivalent to existing community, regional, or statewide services;

9 (6) the project [ADDITIONAL NURSING HOME BEDS OR THE
10 HEALTH CARE FACILITY] demonstrates financial feasibility, including long-term
11 viability, and what the financial effect will be on consumers and the state; and

12 (7) the sponsor has demonstrated cost effectiveness through
13 considering the availability of appropriate, less costly alternatives of providing the
14 services planned.

15 (c) The department shall grant a sponsor a certificate of need or modify a
16 certificate of need [THAT AUTHORIZES NURSING HOME BEDS OR THAT IS
17 FOR A HEALTH CARE FACILITY THAT IS A NURSING HOME] if the
18 department finds that the sponsor meets the standards established in or under this
19 chapter.

20 * Sec. 6. AS 18.07.071(b) is amended to read:

21 (b) The department may grant a sponsor a temporary certificate for the
22 temporary operation of a category of health service if the sponsor shows by affidavit
23 or formal hearing

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

25 (2) adverse effect to the public interest by reason of delay occasioned
26 by compliance with the requirements of AS 18.07.043 [AS 18.07.041, 18.07.043,] and
27 application procedures prescribed by regulations under this chapter.

28 * Sec. 7. AS 18.07.071(c) is amended to read:

29 (c) A temporary certificate granted under (b) of this section does not confer
30 vested rights on behalf of the applicant. The department shall impose those special
31 limitations and restrictions concerning duration and right of extension that the

1 department considers appropriate. A temporary certificate may not be granted for a
 2 period longer than necessary for the sponsor to obtain review of the action certified by
 3 the temporary certificate under AS 18.07.051. Application for a certificate of need
 4 that will be reviewed under AS 18.07.043 [AS 18.07.041 OR 18.07.043] must
 5 commence within 60 days after [OF] the date of issuance of the temporary certificate.

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

7 (c) A certificate of need shall be suspended if an accusation is filed before the
 8 commencement of activities authorized under AS 18.07.043 [AS 18.07.041 OR
 9 18.07.043] that charges that factors upon which the certificate of need was issued have
 10 changed or new factors have been discovered that significantly alter the need for the
 11 activity authorized. A suspension of a certificate may not exceed 60 days. At the end
 12 of this period or sooner, the department shall revoke or reinstate the certificate.

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

14 (d) A certificate of need may be revoked if

15 (1) the sponsor has not shown continuing progress toward
 16 commencement of the activities authorized under AS 18.07.043 within [AS 18.07.041
 17 OR 18.07.043 AFTER] six months after the date of issuance of the certificate;

18 (2) the applicant fails, without good cause, to complete activities
 19 authorized by the certificate;

20 (3) the sponsor fails to comply with [THE PROVISIONS OF] this
 21 chapter or regulations adopted under this chapter;

22 (4) the sponsor knowingly misrepresents a material fact in obtaining
 23 the certificate;

24 (5) the facts charged in an accusation filed under (c) of this section are
 25 established; or

26 (6) the sponsor fails to provide services authorized by the terms of the
 27 certificate.

28 * Sec. 10. AS 18.07.111(2) is amended to read:

29 (2) "certificate" means a certificate of need issued by the department
 30 under AS 18.07.043 or 18.07.071 [AS 18.07.041, 18.07.043, OR 18.07.071];

31 * Sec. 11. AS 18.07.041 is repealed.

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

3 APPLICABILITY. AS 18.07, as amended by secs. 1 - 11 of this Act, applies to
4 applications for certificates of need that are initially filed on or after the effective date of this
5 Act.

6 * Sec. 13. This Act takes effect immediately under AS 01.10.070(c).



**Tanana
Valley
Clinic**

Family Medical Care
Since 1959

Memorandum

March 28, 2002

To: Legislators

From: Brian Slocum

BS

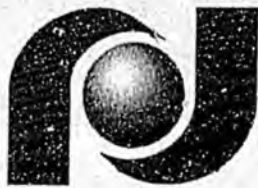
RE: Information Insights study of fiscal impact of revising CON

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

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

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

Thank you.



information insights

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March 25, 2002

To: Brian Slocum
Tanana Valley Clinic

From: Brian Rogers, Principal Consultant

Re: Impact of Certificate of Need Legislation

Executive Summary

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

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

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

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

There is the potential for Medicaid costs to increase for a time, beginning roughly one year from the time the ASC opens and lasting no more than five years. The additional Medicaid cost is likely to be no more than \$200,000 dollars per year (\$80,000 in costs to the state general fund¹), and can not reasonably be expected to exceed \$500,000 (\$200,000 in costs to the state general fund) under any realistic circumstances. The additional cost is expected to decrease in every year after the first.

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

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

¹ Basic Alaska Medicaid costs are currently shared between federal funds (59.8 percent) and state general funds (40.2 percent).

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Estimating the Impact of a Freestanding ASC on Medicaid Cost

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

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

The Medicaid cost argument is based on the formula¹ used to determine the amount that a hospital shall be reimbursed for services provided to Medicaid outpatients. This formula is explained in detail in Appendix A. The state multiplies all Medicaid charges submitted by the hospital by a percentage rate and pays the hospital the resulting amount. The percentage rate is based on the outpatient cost-to-charges ratios (reported in the hospital's Medicare Cost Report) of multiple cost centers within the hospital. Thus the amount that the hospital is reimbursed for services provided to Medicaid outpatients is roughly the cost of the services. The numerator of each cost-to-charges ratio may include both fixed costs (which do not vary in the short run with the number of patients treated) and variable costs (which do vary with the number of patients treated).

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

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

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

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

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

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

Period 0 (Construction).

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

Period 1 (Immediately after the ASC opens).

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

Period 2 (Near Term).

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

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

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

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

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

Period 3 (Long Term).

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

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

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

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

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Appendix A: Determination of Medicaid Outpatient Reimbursement Rates**I. ASC Medicaid Rates**

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

II. Acute Care Hospital Medicaid Rates

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

$$1. \quad PR = \frac{\sum((OCCR_i)(MAOPCHRG_i))}{\sum(MAOPCHRG_i)}$$

$$= \frac{\sum(MAOPCOST_i)}{\sum(MAOPCHRG_i)}$$

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

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

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

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

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

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

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

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

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

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

Scenario 1

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

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

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

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

Scenario 2

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

Scenario 3

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

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

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

Scenario 4

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

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Notes

ⁱ Set out in 7 AAC 43.685(c).

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

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



**Tanana
Valley
Clinic**

Family Medical Care
Since 1959

Memorandum

March 28, 2002

To: Legislators

From: Brian Slocum

RE: Analysis of impact of eliminating CON in other states

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

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

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

Thank you.

Certificate of Need Revisited

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

by Daniel N. Mendelson
and Judith Arnold

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

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

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

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

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

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

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

CON's Effectiveness In Acute Care

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

Acute Care Costs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Empirical Specification

Dependent Variables

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

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

for a state's resident population. We also obtained estimates of Medicare spending per elderly enrollee, including total Medicare expenses and Part A and Part B expenditures.³ Unpublished estimates of personal health care expenditures by state and year in total and by component were obtained from HCFA for 1980–1993.⁴ We also analyzed Medicare expenditures for 1980–1993. All monetarily expressed variables were deflated by the all-items Consumer Price Index.

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

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

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

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

by data availability.⁵ Information on the first three variables came from the *Hospital Statistics* (AHA 1977–1994). Data for the fourth came from the SMG Marketing Group (1984–1995). For the variable industry organization, we defined dependent variables for the for-profit share of hospital beds⁶ for 1976–1993 based on *Hospital Statistics* and the HMO enrollments as a fraction of the state population, information taken from the Group Health Association of America's *National Directory of HMOs* (GHAA 1977–1994). We used data for 1976–1993 in our analysis of HMO market share.

Examining Certificate-of-Need Laws

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

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

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

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

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

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

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

Hospital Rate-Setting

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

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

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

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

Reimbursement

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

Price Competition

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

Area Characteristics

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

Other Explanatory Variables

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

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

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

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

Functional Form

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

Results

Effects of Certificate-of-Need Laws

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

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

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