

ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10220 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

**Table 1** Expenditures on Acute Care Services

	Medical Spending/Pop. (HCFA)				Spending Per Medicare Eligible Age 65+		
	Total Spending	Acute Spending	Hospital Spending	Physician Spending	Total Medicare	Part A	Part B
<b>CERTIFICATE-OF-NEED REGULATION</b>							
Section 1122	-.012 <sup>b</sup> (.005)	-.018 <sup>b</sup> (.007)	-.001 (.010)	-.029 <sup>c</sup> (.015)	-.049 <sup>c</sup> (.029)	-.090 <sup>b</sup> (.045)	.053 (.063)
Young CON	.006 (.006)	.001 (.007)	.0002 (.010)	-.0001 (.015)	.002 (.029)	-.013 (.045)	.041 (.064)
Mature CON	-.004 (.003)	-.009 <sup>b</sup> (.004)	-.005 (.006)	.004 (.009)	.029 <sup>c</sup> (.017)	-.008 (.027)	.163 <sup>a</sup> (.038)
CON Lifted	-.004 (.003)	-.006 <sup>c</sup> (.004)	-.010 <sup>c</sup> (.006)	.003 (.009)	.032 <sup>c</sup> (.017)	.017 (.026)	.143 <sup>a</sup> (.038)
<b>HOSPITAL RATE-SETTING</b>							
Prospective Payment System (PPS)	.042 <sup>a</sup> (.016)	.018 (.022)	.091 <sup>a</sup> (.031)	.103 <sup>b</sup> (.045)	-.254 <sup>a</sup> (.083)	-.401 <sup>a</sup> (.128)	.169 (.182)
Young Mandatory Prospective	-.038 <sup>b</sup> (.015)	-.036 <sup>c</sup> (.021)	-.063 <sup>b</sup> (.029)	-.065 <sup>c</sup> (.043)	.051 (.082)	-.024 (.126)	.253 (.178)
Old Mandatory Prospective	-.011 <sup>c</sup> (.006)	-.017 <sup>c</sup> (.009)	-.022 <sup>c</sup> (.012)	-.027 <sup>c</sup> (.018)	-.073 <sup>b</sup> (.034)	-.101 <sup>c</sup> (.053)	-.052 (.075)
<b>REIMBURSEMENT</b>							
Medicaid Share	.059 <sup>a</sup> (.022)	.082 <sup>a</sup> (.030)	.153 <sup>a</sup> (.042)	-.039 (.063)	.125 (.120)	.330 <sup>c</sup> (.185)	-.322 (.261)
Medicare Share	-.179 <sup>a</sup> (.017)	-.204 <sup>a</sup> (.023)	-.330 <sup>a</sup> (.033)	-.092 <sup>b</sup> (.047)	.008 (.089)	.124 (.139)	-.246 (.193)
<b>COMPETITION</b>							
HMO Market Shares	.033 (.025)	.011 (.034)	.041 (.049)	.031 (.072)	-.178 (.137)	-.330 <sup>c</sup> (.208)	-.420 (.295)

Table 1 Continued

	Medical Spending/Pop. (HCFA)				Spending Per Medicare Eligible Age 65+		
	Total Spending	Acute Spending	Hospital Spending	Physician Spending	Total Medicare	Part A	Part B
<b>AREA CHARACTERISTICS</b>							
Income Per Capita	.006 (.012)	-.002 (.016)	.011 (.023)	.071 <sup>b</sup> (.034)	-.249 <sup>a</sup> (.065)	-.168 <sup>c</sup> (.099)	-.513 <sup>a</sup> (.141)
General Practitioner	.061 <sup>a</sup> (.016)	.089 <sup>a</sup> (.021)	.088 <sup>a</sup> (.030)	.019 (.044)	.442 <sup>a</sup> (.084)	.521 <sup>a</sup> (.129)	.599 <sup>a</sup> (.183)
All Physicians	-.008 (.026)	-.001 (.033)	.069 <sup>c</sup> (.046)	.135 <sup>b</sup> (.067)	.412 <sup>a</sup> (.128)	.334 <sup>c</sup> (.197)	1.081 <sup>a</sup> (.272)
Elderly	.065 <sup>a</sup> (.021)	.100 <sup>a</sup> (.028)	.051 (.039)	.054 (.059)	-.085 (.112)	-.163 (.172)	.207 (.243)
Density	-.087 <sup>a</sup> (.016)	-.127 <sup>a</sup> (.021)	-.079 <sup>a</sup> (.030)	.003 (.045)	-.087 (.085)	-.112 (.131)	-.171 (.186)
Service Wage	.046 <sup>a</sup> (.013)	.045 <sup>b</sup> (.018)	-.122 <sup>a</sup> (.025)	.218 <sup>a</sup> (.038)	.101 <sup>c</sup> (.070)	.230 <sup>b</sup> (.108)	-.053 (.152)
<b>OTHER</b>							
Lagged Dependent	.847 <sup>a</sup> (.022)	.815 <sup>a</sup> (.026)	.732 <sup>a</sup> (.030)	.508 <sup>a</sup> (.036)	.458 <sup>a</sup> (.034)	.358 <sup>a</sup> (.044)	.105 <sup>b</sup> (.042)
Time	.008 <sup>a</sup> (.002)	.012 <sup>a</sup> (.002)	.016 <sup>a</sup> (.003)	.034 <sup>a</sup> (.003)	.035 <sup>a</sup> (.004)	.041 <sup>a</sup> (.006)	.068 <sup>a</sup> (.009)
R <sup>2</sup>	.998	.997	.993	.989	.993	.985	.970
R <sup>2</sup> (C)	.998	.997	.992	.988	.993	.983	.967
F	4547	2693	1136	770	1259	536	275
N	623	623	623	623	623	623	623

<sup>a</sup> Significant at the 1 percent level (two-tail test).

<sup>b</sup> Significant at the 5 percent level (two-tail test).

<sup>c</sup> Significant at the 10 percent level (two-tail test).

for total hospital spending. The largest negative effect was for Medicare Part A, which was directly affected by section 1122 controls.

Mature CON reduced bed supply by two percent (long-run effect). However, it raised hospital expense per adjusted patient day and per admission, and also increased hospital profitability (Table 2). Lifting CON had no impact on any of these dependent variables. Section 1122 lowered hospital profits, but the magnitude of this effect appears to be implausibly large.

Mature CON or its removal had no effect on diffusion of technology such as open-heart surgery units, organ transplant units, or ambulatory surgery units (Table 3). Availability of organ transplant units rose immediately after the implementation of CON, but this result could reflect the low number of such units in most states. Pre-CON was not included in any of the technology regressions, and young CON was not included in the regressions for ambulatory surgery, because there were no "young" programs during the observational periods for this analysis.

Both mature CON and CON lifted had positive influences on the for-profit share of the hospital market (Table 4). If a policy objective of retaining CON is to keep the for-profit market share in check, the empirical evidence, if anything, suggests that CON has the opposite effect.

Holding other factors constant, none of the CON variables affected HMO market share; however, the signs on the statistically insignificant coefficients are negative, suggesting that CON may have impeded HMO growth. Section 1122 had significantly positive effects on the for-profit share and a positive but insignificant effect on the HMO share.

In an alternative specification of CON, not shown, we examined whether our findings would persist once we had accounted for differences in stringency of CON across different states. The simplest way of measuring stringency is in terms of thresholds for coverage. States with high thresholds have less stringent programs insofar as fewer projects would qualify for review. We analyzed thresholds for capital and major medical equipment separately, and found very few instances in which these had an impact on the many measures examined. States with high capital thresholds (i.e., with less stringent CON) had lower Part B Medicare spending than did states with no CON.

When stringency was defined in terms of the Lewin-ICF categories described earlier, we found that states with limited CON had worse results than states with no CON. Limited CON states had higher hospital spending per capita and higher Medicare Part B spending per person over age sixty-five. For stringent CON, the effect on hospital spending

was not observed. However, in these states too, Part B spending was comparatively high.

### Hospital Rate-Setting

Young state hospital rate-setting programs reduced the rate of growth in hospital expenditures overall, and thereby lowered growth rates in both acute care spending and total spending on personal health care services as well (Table 1). The magnitude of effects was lower for the mature programs. There were no statistically significant effects on expenditures for physicians' services. For Medicare, the mature programs had a stronger effect on hospital spending and on total spending. State rate-setting had no statistically significant effects on hospital bed supply, intensity, hospital profitability (Table 2), or on diffusion of technology with the exception of organ transplant units (Table 3).

Although PPS reduced Medicare expenditures through its effect on Part A expenditures, it seems to have had a positive effect on spending overall. These effects are not attributable to a secular trend in expenditures since we included a time trend as a separate explanatory variable. In contrast to state hospital rate-setting, PPS was negatively related to expense per adjusted admission, to expense per patient day, and to for-profit hospital market share, but was positively related to the HMO market share (Table 4).

### Price Competition

Holding other factors constant, the HMO market share was associated with lower hospital bed supply, lower expense per adjusted admission, and lower diffusion of open-heart surgery units, but with greater diffusion of organ transplant units. For expenditures, only the effect of HMO share on Part A expenditures is negative and statistically significant at the 10 percent level or better. We split the sample between the periods 1988 and before and 1989 and after (results not presented). The negative effects of HMO share on Part A Medicare, on diffusion of open heart units, and on the number of hospital beds were statistically significant for the earlier but not for the later period. The HMO coefficient on profit was negative and statistically significant at the 10 percent level for the earlier period, but was insignificant for the latter.

**Table 2** Hospital Beds, "Intensity," and Profitability

	Beds per 1,000 Population	Intensity		Hospital Profits
		Expense per Adjusted Patient Day	Expense per Adjusted Admission	
<b>CERTIFICATE-OF-NEED REGULATION</b>				
Section 1122	-.0004 (.008)	-.007 (.012)	-.002 (.009)	-.272 <sup>b</sup> (.130)
Pre-CON	-.002 (.006)	.007 (.009)	.003 (.007)	.263 <sup>a</sup> (.101)
Young CON	-.007 (.006)	.006 (.008)	.007 (.006)	.256 <sup>a</sup> (.093)
Mature CON	-.008 <sup>c</sup> (.004)	.011 <sup>c</sup> (.006)	.010 <sup>b</sup> (.005)	.153 <sup>b</sup> (.069)
CON Lifted	.002 (.005)	-.001 (.008)	.004 (.006)	.018 (.085)
<b>HOSPITAL RATE-SETTING</b>				
Prospective Payment System (PPS)	-.095 <sup>a</sup> (.025)	-.125 <sup>a</sup> (.035)	-.105 <sup>a</sup> (.027)	-.395 (.400)
Young Mandatory Prospective	-.005 (.018)	.027 (.026)	.038 <sup>c</sup> (.020)	-.130 (.382)
Old Mandatory Prospective	.006 (.010)	-.003 (.014)	.005 (.011)	.157 (.173)
<b>REIMBURSEMENT</b>				
Medicaid Share	.129 <sup>a</sup> (.037)	.081 <sup>c</sup> (.053)	.176 <sup>a</sup> (.041)	-.689 (.613)
Medicare Share	-.003 (.023)	.171 <sup>a</sup> (.034)	.049 <sup>c</sup> (.026)	2.020 <sup>a</sup> (.388)
<b>COMPETITION</b>				
HMO Market Shares	-.111 <sup>a</sup> (.041)	-.003 (.054)	-.186 <sup>a</sup> (.045)	-.897 <sup>c</sup> (.604)
<b>AREA CHARACTERISTICS</b>				
Income Per Capita	-.044 <sup>b</sup> (.018)	.021 (.025)	.004 (.019)	-.019 (.306)
General Practitioner	.042 <sup>b</sup> (.017)	.032 (.024)	.026 (.019)	-.062 (.290)
All Physicians	.215 <sup>a</sup> (.029)	-.002 (.044)	.097 <sup>a</sup> (.033)	-1.096 <sup>b</sup> (.469)
Elderly	.100 <sup>a</sup> (.026)	-.019 (.036)	-.070 <sup>b</sup> (.028)	-.268 (.414)

Table 2 Continued

	Beds per 1,000 Population	Intensity		Hospital Profits
		Expense per Adjusted Patient Day	Expense per Adjusted Admission	
Density	-.024 (.020)	-.005 (.029)	.066 <sup>a</sup> (.022)	-.125 (.312)
Service Wage	-.032 <sup>c</sup> (.020)	.124 <sup>a</sup> (.028)	.032 <sup>c</sup> (.022)	1.175 <sup>a</sup> (.320)
OTHER				
Lagged Dependent	.616 <sup>a</sup> (.021)	.803 <sup>a</sup> (.023)	.801 <sup>a</sup> (.021)	.318 <sup>a</sup> (.033)
Time	-.007 <sup>a</sup> (.001)	.009 <sup>a</sup> (.002)	.006 <sup>a</sup> (.001)	.075 <sup>a</sup> (.017)
R <sup>2</sup>	.986	.986	.990	.621
R <sup>2</sup> (C)	.985	.984	.989	.586
F	818	802	1178	18
N	863	863	863	818

<sup>a</sup> Significant at the 1 percent level (two-tail test).

<sup>b</sup> Significant at the 5 percent level (two-tail test).

<sup>c</sup> Significant at the 10 percent level (two-tail test).

## Discussion

The major findings about CON can be summarized as follows: first, we found no surge in expenditures after CON was lifted; second, despite a statistically significant reduction by mature programs on acute spending per capita, there was no corresponding reduction in total per capita spending (apparently due to offsetting expenditures on nonhospital services).

Empirical analysis of CON is an old topic. What is new or relatively new about our analysis is the research on the effects of lifting CON, the broad range of cost-related outcomes of CON studied, and the analysis of CON and other factors on a recently released data base of personal health care expenditures and their components. Particularly given the long history of empirical analysis of CON, it is important to review our evidence in the context of past research. A scorecard of previous studies of the effects of CON is shown in Table 5. Overall, the record for CON as a cost-containment mechanism appears to be mixed at best. If anything, our results provide slight optimism for CON's cost-containing potential relative to some other studies.

To date, only one other study has used the HCFA per capita spending

Table 3 Diffusion of Technology

	Open Heart Units/ Million	Organ Transplant Units/Million	Hospital- based Units/ Million	Total Units/ Million
<b>CERTIFICATE-OF-NEED REGULATION</b>				
Section 1122	-.069 <sup>c</sup> (.046)	-.084 (.128)	.001 (.022)	.005 (.025)
Young CON	-.005 (.046)	.235 <sup>c</sup> (.141)	(—) (—)	(—) (—)
Mature CON	-.009 (.027)	-.071 (.078)	.007 (.015)	.012 (.017)
CON Lifted	.022 (.027)	.019 (.074)	.007 (.012)	.021 (.013)
<b>HOSPITAL RATE-SETTING</b>				
Prospective Payment System (PPS)	.405 <sup>a</sup> (.140)	-.278 (.407)	.206 <sup>a</sup> (.073)	.155 <sup>c</sup> (.081)
Young Mandatory Prospective	-.082 (.128)	-1.427 <sup>a</sup> (.345)	.009 (.095)	.085 (.106)
Old Mandatory Prospective	-.031 (.054)	.050 (.146)	.022 (.028)	.034 (.031)
<b>REIMBURSEMENT</b>				
Medicaid Share	.181 (.190)	-1.22 <sup>b</sup> (.556)	-.063 (.102)	-.003 (.113)
Medicare Share	-.334 <sup>b</sup> (.146)	.669 (.418)	-.022 (.095)	.023 (.105)
<b>COMPETITION</b>				
HMO Market Shares	-.495 <sup>b</sup> (.228)	2.351 <sup>a</sup> (.645)	-.050 (.118)	.149 (.128)
<b>AREA CHARACTERISTICS</b>				
Income Per Capita	.044 (.101)	.144 (.300)	-.136 <sup>b</sup> (.056)	-.113 <sup>c</sup> (.062)
General Practitioner	.339 <sup>b</sup> (.133)	.071 (.469)	.025 (.078)	-.109 (.087)
All Physicians	.299 <sup>c</sup> (.197)	.236 (.615)	-.043 (.099)	-.025 (.109)
Elderly	-.023 (.174)	.416 (.560)	.278 <sup>a</sup> (.099)	-.001 (.108)
Density	-.117 (.133)	-.253 (.416)	-.216 <sup>a</sup> (.070)	.066 (.076)
Service Wage	.060 (.113)	-.755 <sup>b</sup> (.345)	.041 (.059)	.080 (.065)

Table 3 Continued

	Open Heart Units/ Million	Organ Transplant Units/Million	Hospital- based Units/ Million	Total Units/ Million
OTHER				
Lagged Dependent	.543 <sup>a</sup> (.036)	.409 <sup>a</sup> (.039)	.477 <sup>a</sup> (.043)	.639 <sup>a</sup> (.038)
Time	.006 (.006)	.036 <sup>b</sup> (.017)	-.012 <sup>a</sup> (.003)	.00001 (.003)
R <sup>2</sup>	.931	.750	.988	.981
R <sup>2</sup> (C)	.922	.716	.986	.979
F	112	22	532	337
N	617	541	479	479

<sup>a</sup> Significant at the 1 percent level (two-tail test).

<sup>b</sup> Significant at the 5 percent level (two-tail test).

<sup>c</sup> Significant at the 10 percent level (two-tail test).

data to assess the impact of CON. Examining data through 1982, Lanning, Morrissey, and Ohsfeldt (1991) found that after controlling for the fact that per capita spending was significantly different in states which adopted CON early, CON was associated with a 20.6 percent *increase* in hospital spending and a nine percent increase in spending on other health care. The net impact was a 13.6 percent increase in per capita spending on personal health care services. Using data derived from the annual *Hospital Statistics* on per capita hospital spending through 1990 (AHA 1977–1994) and a method that accounted for endogeneity of CON, Antel, Ohsfeldt, and Becker (1995) reported that CON had no impact on this form of spending, although they found that section 1122 reduced hospital spending. Without controlling for the endogeneity of CON, the coefficient on the CON variable was negative but very small, with a t-ratio of  $-.47$ . Taking account of endogeneity, the coefficient on CON became positive and statistically significant at the 10 percent level. It is noteworthy that explicitly accounting for CON's endogeneity made it appear to perform *less* well. Salkever and Bice (1976) found no impact of CON on total hospital operating costs per capita. Likewise, an earlier study by the Federal Trade Commission found that CON had no impact on hospital costs, but also found that section 1122 had a negative influence (Sherman 1988). By contrast, in our study, neither mature CON nor section 1122 had an impact on this type of expenditure, although both were associated with lower growth in acute care spending.

**Table 4** Industry Organization

	For-Profit Share of Beds	HMO Market Share
<b>CERTIFICATE-OF-NEED REGULATION</b>		
Section 1122	.211 <sup>b</sup> (.101)	.436 (.364)
Pre-CON	.121 (.115)	-.279 (.312)
Young CON	.149 (.108)	-.176 (.285)
Mature CON	.120 <sup>c</sup> (.064)	-.155 (.213)
CON Lifted	.139 <sup>b</sup> (.059)	-.335 (.234)
<b>HOSPITAL RATE-SETTING</b>		
Prospective Payment System (PPS)	-.800 <sup>b</sup> (.364)	1.357 (1.154)
Young Mandatory Prospective	.369 (.578)	.971 (.875)
Old Mandatory Prospective	-.195 (.157)	.341 (.444)
<b>REIMBURSEMENT</b>		
Medicaid Share	.329 (.420)	.938 (1.575)
Medicare Share	.513 <sup>c</sup> (.320)	3.837 <sup>a</sup> (1.008)
<b>COMPETITION</b>		
HMO Market Shares	.255 (.589)	(—) (—)
<b>AREA CHARACTERISTICS</b>		
Income Per Capita	.289 (.243)	.0001 <sup>c</sup> (.0001)
General Practitioner	.751 <sup>a</sup> (.263)	-.075 <sup>a</sup> (.024)
All Physicians	.016 (.370)	-1.247 <sup>a</sup> (.311)
Elderly	-.684 <sup>c</sup> (.352)	.035 <sup>a</sup> (.053)
Density	.003 (.248)	-.0002 (.0006)
Service Wage	-.700 <sup>b</sup> (.294)	.012 <sup>a</sup> (.004)

Table 4 Continued

	For-Profit Share of Beds	HMO Market Share
OTHER		
Lagged Dependent	.585 <sup>a</sup> (.039)	.879 <sup>a</sup> (.019)
Time	.016 (.013)	.038 (.028)
R <sup>2</sup>	.961	.976
R <sup>2</sup> (C)	.955	.974
F	154	463
N	456	815

<sup>a</sup> Significant at the 1 percent level (two-tail test).

<sup>b</sup> Significant at the 5 percent level (two-tail test).

<sup>c</sup> Significant at the 10 percent level (two-tail test).

In our analysis, adoption of CON was certainly exogenous, but eliminating CON may have been endogenous; that is, it was more likely to have occurred in states where legislatures perceived that cost increases were under control without relying on CON. To ascertain whether this was so, we specified CON lifted and the lagged dependent variable as endogenous variables. Instrumental variables excluded from the main equations were the Blue Cross-Blue Shield market share; share of government hospital beds; population; and values of these variables lagged one year. CON lifted, specified as an endogenous variable, had either no effect or a more negative impact on cost than when the variable was assumed to be exogenous. If the above argument held, one would have expected CON lifted to have had a more positive effect on cost when CON lifted was specified to be endogenous.

Further, in analysis not presented, we used a method developed by Hatanaka (1974) to correct for autocorrelated error terms in a pooled time series cross-section. We found some autocorrelation, both negative and positive, but the correction had only minor effects on our results.

Two newer studies by Lewin-ICF (Lewin-ICF and Alpha Center 1991; Lewin-ICF 1992a) took account of differences in CON stringency and found that CON had a negative impact on hospital costs. This evidence conflicts with ours, since, after accounting for stringency, we did not find that CON had a greater cost-constraining influence. On balance, we believe our results merit more confidence since we controlled for many more influences other than CON.

We found that mature CON reduced hospital bed supply per capita

**Table 5** Empirical Studies of the Impact of CON on Hospital Costs

Major Impact	Number of Studies Showing:		
	Decrease	No Effect	Increase
<b>Health Spending</b>			
Spending per capita	0	0	1
Hospital expenses per resident	0	3	2
Total hospital costs	2	1	0
<b>Supply/Utilization</b>			
Hospital capital expenditures	2	5	2
Hospital bed supply	2	3	1
Admissions per 1,000	0	2	0
<b>Intensity</b>			
Cost per patient day	2	1	2
Average length of stay	0	2	0
Cost per admission	0	2	6
<b>Resource Mix</b>			
Assets per bed	0	3	1
Labor use per bed	0	1	1
<b>Market Structure</b>			
For-profit share of beds	1	3	1
Public share of beds	1	0	0

population, but could detect no increase in bed supply following removal of CON. The magnitude of the reduction we detected was small—two percent from mature CON. Using an estimate from Ginsburg and Koretz (1983) that a 1 percent reduction in bed supply results in a .4 percent decline in admissions (the predicted reduction in admissions), the 2 percent reduction in supply translates into less than a 1 percent reduction in admissions. For this reason, it may not be surprising that we show only a minor (statistically insignificant) decline in hospital spending.

One of the earliest studies of CON found that CON reduced hospital bed supply, but also led to increased investment per bed (Salkever and Bice 1976, 1979). The result was no net saving on capital expenditures overall—simply a diversion of spending away from beds into other types of capital equipment that, due to less precise standards for judging need, was less well controlled. Sloan and Steinwald (1980b) also found a compensatory response to CON regulation, but it took the form of higher spending on labor rather than greater investment in other forms of capital. Since then, most studies have found that CON had no detectable impact

on hospital bed supply (Eastaugh 1982; Ashby 1984; Lewin-VHI 1995) or on hospital capital spending (PAI-US 1980; Eastaugh 1982; Begley, Schoeman, and Traxler 1982; Ashby 1984; Wedig, Hassan, and Sloan 1989). In fact, only two studies since the landmark study by Salkever and Bice (1976) found evidence that CON reduces bed supply (Joskow 1980; Begley, Schoeman, and Traxler 1982). Whether the true effect of CON is slightly negative or not, there are certainly better ways to control hospital bed supply, in particular by promoting HMO growth. The effect of HMO share on bed supply in our analysis was over ten times that of mature CON.

We found that mature CON increased cost per adjusted patient day and per admission. The mechanism is presumably that cost-increasing investments are unconstrained or, as Sloan and Steinwald found, there is a compensatory response in use of labor, and as a consequence there is an increase in operating costs. Many previous studies have reported results consistent with ours (Salkever and Bice 1979; Sloan and Steinwald 1980a; Sloan 1981; Farley and Kelly 1985; Noether 1988; Anderson et al. 1989; Lewin-ICF and Alpha Center 1991; and Antel, Ohsfeldt, and Becker 1995). Fewer have found no impact (Sloan 1983; Lewin-VHI 1995).

In this study, the now-defunct section 1122 program had no effect on either cost measure, a result consistent with Antel, Ohsfeldt, and Becker 1995; however, Noether (1988) reported that section 1122 reduced cost per admission by seven percent.

We reviewed eight previous studies that examined the impact of CON on diffusion of technology. In nearly seventy separate tests of the relationship between CON and the rate or extent of diffusion contained in these studies, only about one-third found that CON retards diffusion; a few, like our result for organ transplant units, found that CON accelerates diffusion, but the majority found no effect in either direction. None dealt with ambulatory surgery units; we found that CON had no effect on their diffusion.

Taken at face value, these studies suggest that CON appears to have slowed diffusion of the following technologies: hospital-based cardiac catheterization units, CAT-scan units, and MRI units (Lewin-ICF and Alpha Center 1991); open-heart surgery units (Russell 1979; Lewin-ICF and Alpha Center 1991); hip arthroplasty and morbid obesity surgery (Sloan et al. 1986); cobalt therapy (Russell 1979); and nonhospital-based renal dialysis (Ford and Kaserman 1993).

Yet, for the following reasons, even these favorable findings do not provide unambiguous support for the view that CON retards diffusion of expensive technologies. First, there are conflicting results. For example, although Lewin-ICF (1992a and Lewin-ICF and Alpha Center 1991)

found that CON reduced diffusion of MRIs, Teplensky et al. (1995) reported that more stringent CON policies caused an increase in diffusion of such units. Second, some results are counterintuitive. For example, Sloan et al. (1986) reported that CON had no impact on diffusion of coronary bypass graft surgery (CABG) units, a result consistent with the findings reported here. However, the same analysis showed that CON slowed diffusion of hip arthroplasty and morbid obesity surgery. The latter procedures were not subject to CON review, whereas CABG is subject to review in the vast majority of states with CON. Further, explicit guidelines for review had been developed by the agency responsible for federal oversight of state CON programs. No such guidelines existed for the other types of surgery.

There has been comparatively little research on the effect of CON on market structure. Concerns have been expressed that, absent CON, there will be a flood of for-profit entrants. However, the limited empirical evidence suggests no differential effect of CON on for-profit hospitals (Sloan and Steinwald 1980b). Using a time series of state cross-sections, Wedig, Hassan, and Sloan (1989) showed that the for-profit market share was unrelated to CON. In the current study, we found that mature CON stimulated growth of the for-profit hospital market share, and holding other factors constant, that the share was higher during the immediate period after CON was lifted. Rather than confirming the fears of those who favor retaining CON, our result for CON lifted could reflect a spillover from mature CON. This explanation seems especially likely, given the result for mature CON.

Our finding that CON had negative, albeit insignificant effects on HMO market penetration could reflect endogeneity, although this should have been handled by our fixed-effects analysis. That is, states with low HMO market shares may be reluctant to lift CON. We examined HMO market shares in the year that states lifted CON. They ranged from a high of 24.0 percent for California to lows of 1 percent or less for Idaho, New Mexico, South Dakota, and Wyoming. Preferred provider organization (PPO) penetration was also very low in these states (unpublished data from the American Medical Care and Review Association). Clearly, these states had something other than the presence of high HMO or PPO penetration in mind when they dropped CON. In many of the states that lifted CON, the HMO market share was below the national mean. In all of the states, there has been appreciable growth in managed care since they dropped CON.

Unlike research in many areas of health policy, research into CON

effects on acute care costs provides a rather clear answer. CON has not succeeded in cost containment. Other cost-containment programs appear to work better, but even they appear to have lost their effectiveness as they matured. Certainly, from the regression results presented here and from the descriptive evidence we analyzed but have not reported, there is no reason to fear an expenditure surge after CON laws were lifted. But might CON laws be retained for other reasons?

Might CON improve quality of care? It might do this in at least two ways—first, by assuring adequate patient volume and second, by denying entry to facilities that lack the capacity to deliver high-quality care. There is substantial evidence for one aspect of the former, but no “hard” information on the latter.

Luft et al. (1990) compiled an extensive review of the literature on the volume-outcome relationship that we supplemented with our own review of research published in the 1990s. More than one hundred studies have examined the relationship between hospital volume and outcomes, either mortality or complication rates (e.g., infection rates, rates of reoperation), excessive lengths of stay, or other indicators of patient health status. Although the underlying mechanism is not understood, most studies show higher rates of good outcomes in higher volume facilities. By contrast, there are far fewer studies of the relationship between physician volume and outcomes, and for reasons that are also not well understood, the link between volume and outcomes is less clear.

If the relationship between hospital volume and outcomes is accepted as valid, the question remains whether or not CON increases volume. Only one study has assessed the effect of CON on outcomes directly. Analyzing data from nearly 1,000 hospitals, Shortell and Hughes (1988) found that states with more stringent CON policies or more stringent hospital rate-setting experienced higher mortality rates. Although this analysis would suggest that lifting CON may result in favorable effects on mortality, such an inference would be having it both ways. Given that there appears to be no surge in costs following removal of CON, nor much if any effect of mature or stringent CON on hospital costs, nor much if any effect on diffusion of technology, why CON should have an *adverse* impact on mortality defies explanation.

Finally, there is the potential impact of CON on access. The 1974 National Health Planning and Resources Development Act, which mandated that states have CON, contained several provisions designed to promote better access to care. For example, consumer members were

required to outnumber provider members on local planning boards (Sloan 1988). Also, any Health Systems Agency plan that failed to address needs of low-income persons was subject to challenge at a public hearing.

There is a paucity of empirical studies of effects of CON on access to acute care services. One study conducted in Florida reported that a hospital's success in obtaining CON approval was consistently related to the amount of indigent care that it provided (Campbell and Fournier 1993). A study of California hospitals found evidence consistent with the hypothesis that hospital regulators reward large uncompensated care providers with profitable CON licenses, although no CON variables were actually used in estimating the amount of uncompensated care given by providers (Campbell and Ahern 1993).

Even though this information is suggestive, it is difficult to use it as a basis for continuing to support CON. First, it only applies to two states. Second, there must be more efficient ways to promote access than conferring monopoly franchises on facilities. Efforts to promote access are likely to be more productive if they are focused on primary care providers. Lack of adequate and timely primary care has been found to lead to a significant number of avoidable hospitalizations (Billings et al. 1993)

Earlier studies were more favorable than ours to other regulatory programs such as PPS and state hospital rate-setting relative to CON. It is not that CON has become more effective, but rather that the other programs became worse performers in terms of cost containment as the provider community became more familiar with them.

### **Conclusion**

Our empirical analysis of effects of CON on costs revealed that, at best, CON has had a modest cost-containing influence on hospital and other acute care services. We found no evidence for a surge in acquisition of new facilities or in costs following removal of CON. States that lifted CON did not experience a rise in spending on hospital and physicians' services relative to those that retained it. The conclusion of lack of surge even holds for facilities such as ambulatory surgery units that have experienced substantial growth in recent years. It is doubtful that CON has had much of a positive or negative influence on quality of care. CON may have improved access, but the empirical evidence for this is quite meager.

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April 2, 2002

Members of the HESS Committee  
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Juneau, Alaska

I am writing in opposition to HB 407. I believe the elimination of Certificate of Need (CON) in smaller isolated communities such as Fairbanks would have significant long term consequences for Medicaid expenditures and ultimately for the availability of essential medical services for all members of these communities.

For the past 27 years, I have taught and done research in the area of health economics and health policy at the University of Washington in Seattle. In that time, I have participated in numerous studies of the organization of health care markets, and several studies aimed at evaluating the impact of CON specifically. I was part of the study team that analyzed proposals to alter Washington's CON for the state legislature. I am among the researchers working with the Center for Studying Health Systems Change in Washington, D.C. to track changes in the health care financing and delivery systems of 12 communities around the United States. I visited Fairbanks in the spring of 1999, where I gave a session on the economics of health care in rural communities to the board of Fairbanks Memorial Hospital. During that visit, and another in September of 2000 when I spoke before a meeting of the Alaska Hospital and Nursing Home Association, I had the opportunity to talk with many members of the Fairbanks health care community.

I come from a discipline with a strong belief in the benefits of competitive markets. However, my work over the last three decades has convinced me that health care is not like pizza. In the market for pizza, we want a good, cheap pepperoni and sausage, and we don't worry that some people can't afford even a slice of plain cheese. We make our own decisions and pay out of our own pockets. In small communities, if the one pizza place goes out of business, we're sorry, but we either bake our own or eat Chinese. Not so for health care. While we want our health care providers to operate

efficiently, we don't value low prices more than quality and availability. Our insurance companies pay for the heart surgery that our doctor tells us we need, and we *do* care that our neighbor can't pay for his chronic diabetes treatment. If the only hospital in town goes broke, doing our own surgery is not an option.

Certificate of Need is a central component of how communities – especially smaller communities like Fairbanks – assure that competition doesn't dismantle the delicate interdependent web of financing that is necessary to assure the survival of essential medical services. If all patients and all payers paid the full cost of treatment, we could ask hospitals to behave more like pizza parlors. But the reality is they don't, they can't, and the likelihood that they ever will is small. CON doesn't *prohibit* competition, it just provides a process through which communities can make decisions about when and what kind of competition will yield benefits that outweigh its costs. It allows communities to be responsible stewards of important community assets (their hospitals), which they – as in the case of Fairbanks Memorial Hospital – generated funds to build.

Some additional thoughts to consider:

- Repeal of CON in Ohio was followed by 13 closures of Level 1 obstetric and newborn services, leaving 2 counties without any services
- Since repeal, 152 ambulatory surgery facilities and 202 diagnostic imaging centers have been added in Ohio, and 16 hospitals have closed
- In Virginia, a legislative panel recommended delaying the loosening of CON controls because of the estimated \$40 million cost of maintaining the financial viability of safety net hospitals that would be required in a competitive environment
- The analysis provided by Brian Rogers of Information Insights is much too simplistic to be useful. His calculations focus on the surgical services that would be provided by the surgery center, and he ignores the impact on other hospital services.
- Market entrants can promise to lower prices and offer charity care, but there is no mechanism to enforce their promises. Experience in other settings suggests that promises are often forgotten.
- While health care facilities provide the laboratories for medical professionals, physicians direct the care process. Ambulatory surgery and imaging services that are owned by physicians are not neutral competitors in the pizza market sense because their physician/owners can direct patients to their own facilities.

- Retaining CON controls on nursing homes and psychiatric hospitals will exacerbate the financial pressures on sole community hospitals if capacity in those areas is restricted and patients are placed in general inpatient beds as a (higher cost) substitute. Since Medicaid pays for a disproportionate share of nursing home and psychiatric services, this substitution will likely increase, rather than decrease, Medicaid expenditures.

In sum, Certificate of Need is not about government control of health care. It is about providing a *process* for communities to have a say in the evolution of the health care delivery systems that they have financed and that are an essential component of a community's infrastructure. I urge you to vote against HB 407, a bill that is likely to raise rather than lower Medicaid expenditures, and which may result in the unraveling of Alaska's health care system.

I would be pleased to respond to any questions, either by telephone or other means.

Sincerely,

Carolyn A. Watts, Ph.D.  
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University of Washington, Seattle, Washington  
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## **MEMBERSHIPS AND APPOINTMENTS**

### State Committees and Appointments

Technical Advisory Committee on Managed Health Care, Washington State Legislature, 1984-85

Working group on Six-Year Health Care Purchasing Plan, 1984-85

Washington State Hospital Commission Committee on UB-82, 1985

Technical Advisory Committee on Reimbursement Alternatives, Washington State Hospital Commission, 1982

Data Policy Committee, Washington State Hospital Commission, 1985-86

Chair, Technical Advisory Committee on Basic Research, Washington Health Project Commission, 1986

Task Force on State Health Policy, Senate Human Services and Corrections Committee, 1986

Supreme Court of the State of Washington, Novack Commission on Attorney Fees and Practice, 1987-1988

Washington State Medical Association, AIDS Task Force, 1987-89

Technical Advisory Committee, Rural Health Policy Commission, Washington State Legislature, 1988

Committee on Tax Reform, Seattle Economists Club, 1988

Advisory Committee, K-12 Study, Health Care Authority, 1990

Department of Health Tertiary Services Advisory Group, 1989-90

State Employee Benefits Board, 1989-1995

Task Force on Medical Savings Accounts, Washington Health Services Commission, 1994

### National Committees and Appointments

Technical Advisory Committee on Hospital Classification, Health Care Financing Administration, 1978

Advisory Committee, State of Georgia Prudent Buyer Prospective Reimbursement System, 1974-1979

Advisory Committee on Case Mix Measurement Conference, American Hospital Association, October 1979

HCFA Grants Review Panel on Prospective Payment and Case Mix, 1984, 1985

Advisory Board to US Department of Labor study of working poor conducted by the Rand Corporation, 1988-1990

Governance Committee, Western Network Executive Health Administration Program, University of Colorado at Denver, 1988-1992

Chair, AUPHA Annual Meeting Management Research Committee, 1993

Proposal Reviewer, Robert Wood Johnson Investigator Awards Program, 1995

Editorial Board, Medical Care Research and Review, 1991-Present

Vice Chair, Program Committee, Sun Valley Forum, 1992-1994.

Member, Advisory Committee, Masters in Health Policy Program, Boise State University, 1996-present

Conference Chair, Risk Segmentation in the Health Care Market, Sponsored by the Robert Wood Johnson Foundation, New Orleans, February 1997

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Veterans Administration, Seattle, 1984-1986  
Health Services Research and Development Steering Committee

Puget Sound Health Systems Agency Ethics Committee Editorial Board, 1985-1986

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Small Grants Review Committee, Alcoholism and Drug Abuse Institute, University of Washington, 1986-1989

Prospective Payment System Planning Committee, University Hospitals, 1987-88

Hospitals Decision and Research Support System Committee, University of Washington Hospitals, 1987

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Dean's Representative to Governance Committee of the Human Services Policy Center, 1991-Present

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- Blough, D. K., C. Madden, & M. Hornbrook. 1999. "Modeling Risk Using Generalized Linear Models." Journal of Health Economics. 18(2):153-172.
- Madden, Carolyn W., Bret P. Mackay, Susan M. Skillman, Marcia Ciol, and Paula Diehr. 2000. "Risk Adjusting Capitation: Applications in Two Populations. Health Care Management Science. 3(2000):101-109.

#### PAPERS ACCEPTED FOR PUBLICATION

Austin, Melissa; D. Arnett; T. Beaty; S. Durfy; R. Fineman; E. Gettig; D. Lochner-Doyle; P. Peyser; J. Sorenson; J. Thompson; C. Watts. Forthcoming. "Opportunities for Public Health Genetics Trainees: An Employer/Workplace Survey." Community Genetics.

#### PAPERS SUBMITTED FOR PUBLICATION

Trude, Sally, J. Christianson, C. Lesser, C. Watts. "Employers' Responses to Rising Premiums: The Community Tracking Study." Submitted to Health Affairs.

#### PAPERS IN PROGRESS

Watts, Carolyn; J. Christianson; S. Trude. "Purchasing Decisions of Public Employers: The Community Health Tracking Study."

#### PAPERS IN NON-REFEREED JOURNALS

Jewell, N., A. Cheadle, R.M. Scheffler, and C.A. Watts. "Mental Health Use in an Insured Population: A Mixed Cohort Design." Proceedings of the American Statistical Association, August 1984.

Madden, C.W., "Universal Health Insurance: An End or a Means?" Frontiers of Health Management, Vol. 6, No. 4, Summer 1990.

Madden, C.W. "Washington's Basic Health Plan: Experimentation in a Turbulent Environment," Washington Public Health. 9(1): 42-43. Winter 1991.

Katz, Aaron, C.W. Madden, and Margo Westfall, "The 1993 Washington State Legislature: Dawn of a New Era," Washington Public Health. Vol 11, Fall 1993.

Madden, C.W. "Public Managed Care in Easterville: A Case of Opportunity," in Ambulatory Health Care Case Studies for the Health Services Executive, (A.Ross & M.Richardson, eds.) Health Information Press, 1995.

Watts, Carolyn. "The Economics Determinants of Health and Illness." Washington Public Health. Fall 2000.

#### ABSTRACTS

Diehr, P., C. Madden, D. Martin, and D. Patrick. Enrollment in a State Program for the Uninsured: Is there adverse selection? (presented at the American Public Health Association 119th Annual Meeting, November, 1991).

Martin, D., C. Madden, P. Diehr and D. Patrick. Evaluation of Washington State's Health Plan for the Uninsured (presented at the Annual Meeting of the Association of Health Services Research, June 1991).

Patrick, D., C. Madden, P. Diehr, D. Martin, A. Cheadle, and S. Skillman. Health Status and Use of Services Among Families With and Without Health Insurance (presented at the Annual Meeting of the American Sociological Association, August, 1991).

## TECHNICAL REPORTS

O'Donoghue, D.P., and C.A. Watts. Estimated Costs for a Program Operated by a Health Care Quality Commission. Institute for Interdisciplinary Studies, June 1972.

Watts, C.A. Blood, Sweat and Tears, or the Continuing Saga of Consumerism. Institute for Interdisciplinary Studies, November 1972.

Watts, C.A. Coverage of Blood Banks Under Phase IV. Cost of Living Council, August 1973.

Watts, C.A. "National Health Insurance: The Crisis Revisited." Unpublished seminar paper, The Johns Hopkins University, May 1973.

Watts, C.A. "Physician Cooperation: Implications for Investment by Nonprofit Hospitals." Unpublished research paper, The Johns Hopkins University, April 1974.

O'Donoghue, D.P., C.A. Watts, et al. Synthesis of Current Evidence of the Effects of Health Care Regulation. Policy Center, Inc., National Science Foundation, Fall 1975.

Watts, C.A., G. Updegraff, H. Grayson, and A. Bryant. Health Care Cost and Price Regulations: Background Discussion and Annotated Bibliography. National Science Foundations, Fall 1975.

Watts, C.A., and G. Updegraff. Regulation of the Quantity of Institutional Facilities and Capital Equipment: Background Discussion and Annotated Bibliography. National Science Foundation, Fall 1975.

Watts, C.A., G. Updegraff, and P. Shaughnessy. Regulation of Other Industries in the United States: Selected Annotated Bibliography. National Science Foundation, Fall 1975.

Watts, C.A. "A Managerial Discretion Model for Hospitals." Doctoral Dissertation, the Johns Hopkins University, 1976.

Hartman, R. and C.A. Watts. The Determination of Average Length of Stay: An Economic Approach. Discussion of Paper #8, Center for Health Services Research, May 1978.

Klasterin, T.D., C.A. Watts, and V. Trivedi. A Study of Hospitals for Prospective Reimbursement. Research and Demonstration Series, Report No. 10, Health Care Financing Administration, Washington, D.C., 1978.

Klasterin, T.D., and C.A. Watts. "A Preliminary Analysis of Section 223 Regulations," Submitted to Health Care Financing Administration, July 1979.

Klasterin, T.D. and C.A. Watts. "The Impact of Case Mix Measures on Hospital Classification." Proceedings of the 2nd International Conference on System Science in Health Care, Montreal, July 14-17, 1980.

Watts, C.A. Antitrust in the Health Professions: Precedents and Projections. HMO Technical

- Assistance Paper, University of Washington, March, 1983.
- Watts, C.A. "Preliminary Report: Washington State Medical Association Study of Uncompensated Care," September 1985.
- Watts, C.A. "Report on Certificate of Need." Office of the Governor, State of Washington, December 1985.
- Watts, C.A. "The Effects of Changes in the Medical Liability Market on Washington Obstetricians." Washington State Medical Association, January 1986.
- Watts, C.A., "A Report to the Legislature on Public Health in the State of Washington." Joint Select Committee on Public Health, January 1986.
- Watts, C.A. "The Uninsured in Washington." Report of Technical Advisory Committee A to the Washington Health Project Commission of the Washington State Legislature, July 1986.
- Watts, C.A. "Medicare Payment in State Veterans Homes: A Study of Feasibility." Submitted to the Washington State Department of Veterans Affairs, July 1986.
- Madden, C.W. "The Prenatal Care Program in Washington State: A Four County Evaluation," Health Policy Analysis Program, April 1987.
- Madden, C.W., "State Employee Insurance: Options", Health Policy Analysis Program, November 1987.
- Madden, C.W. "The Environment Facing Rural Hospitals," Health Policy Analysis Program, May 1988.
- An Evaluation of the Sound Care Plan: Issues of Access, Quality, and Cost, with Aaron Katz and Michelle Bell, Health Policy Analysis Program, July 1989.
- Madden, C.W., and Marcia Schwendiman, Health Policy Choices: A Background and Discussion, Final Report to Governor's Office, State of Washington, October 1988.
- Economic Analysis of Proposed Water Quality Standards for Ground Waters of the State of Washington WAC 2000, with Institute for Public Policy and Management, May 1990.
- An Evaluation of the Sound Care Plan, with Aaron Katz and Michelle Bell, Health Policy Analyses Program, July 1991.
- Evaluation of the Community Alternatives Program, with Alice Porter, Paul Fishman, Aaron Katz, Health Policy Analysis Program, July 1992.
- Evaluation of the Medical Selective Contracting Program, with Marcia Schwendiman, Fred Connell, Paul Fishman, and Aaron Katz, Health Policy Analyses Program, August 1992.
- Madden, C.S., A. Katz. 1995. "Community Benefit, and Not for Profit Health Care: Policy Issues

and Perspectives. SPHCM, University of Washington

Madden, C.W., S.M. Skillman, P. Diehr, D.P. Martin, D.L. Patrick. Revolution and Reform: Lessons from Washington's experimental programs.

Madden, C.W., P. Diehr, D.P. Martin, A. Cheadle. 1994. Insurance status of Families in Washington State.

Cheadle, A., C.W. Madden, P. Diehr, D.L. Patrick, D.P. Martin and S.M. Skillman. 1994. Who Participates and Why in a Subsidized Insurance Plan?: Experience with Washington State's Basic Health Plan

Madden, C.W., S.M. Skillman, A. Cheadle, P. Diehr, D.P. Martin, D.L. Patrick. 1994. Health Insurance for the Low Income: An Evaluation. Final Report. Agency for Health Care Policy and Research, Grant #5-R01-HS060621. Seattle: University of Washington, Department of Health Services.

Madden, C.W., A. Katz. 1995. "Community Benefits and Not for Profit Health Care: Policy Issues and Perspectives." SPHCM, University of Washington.

Madden, C.W., M.T. Stanley, S.M. Skillman, D.K. Blough, B. MacKay, V. Wilson, S. Kilby, M.C. Hornbrook, M. Goodman, G.D. Bennett, L. Dey. 1995. "Risk Distribution Among Competing Health Plans Research and Demonstrations Project. Phase I Final Report." University of Washington: Seattle, WA.

Jansson, Roger, Carolyn Watts, Aaron Katz, Patricia Kuzler, Anna Mastroianni, Jack Thompson, and Andrew McWilliam. 2000. "Genetic Testing in the Workplace: Implications for Public Policy." Institute for Public Health Genetics, University of Washington.

Madden, Carolyn, Bret MacKay, and Susan Skillman. 2001. "Measuring Health Status for Risk Adjusting Capitation Payments in Two Medicaid Populations." Center for Health Care Strategies, Inc. Princeton, New Jersey.

#### BOOK REVIEWS

Williams, W., and C.A. Watts. "Equity in Health Services, Empirical Analysis in Social Policy: A Review." AUPHA Notes, May 1977.

Watts, C.A. "The Market for Human Blood." Inquiry, 16(2):180-181, Summer 1979.

Freund, D., and C.A. Watts. "Health Care Economics." Medical Care.

Watts, C.A. "A Quest for Certainty." AUPHA Program Notes.

Watts, C.A. "Issues in Health Care Economics." Hospital Forum

## REVIEWS FOR JOURNALS

Medical Care  
Inquiry  
Health Services Research  
Research in Law and Economics  
National Science Foundation, Economics Division  
American Hospital Association, Internal Proposal  
National Center for Health Services Research  
Medical Care Research and Review  
Economic Inquiry  
Veterans Administration  
Alaska Science and Technology Foundation  
American Behavioral Science Review

## OTHER

Co-editor (with T.D. Klastorin) of special issue of Journal of Contemporary Business on health care costs.

Attended Emory University Law and Economics Center Legal Institute for Economists, Spring 1981.

## **PRESENTATIONS**

"The Philosophy of Economics as Applied to Health Services Delivery." Presentation to the Western Institute of the Hospital Financial Management Association, Portland, Oregon, February 1976.

Roundtable on Health Economics, Clinical Scholars Program, May 1977.

"Hospital Classification: Conceptual Underpinnings." Seminar presented for the Office of Research, Health Care Financing Administration, Washington, D.C., June 1977.

Discussant, "Estimates of Occupational Injury Risk and Compensating Wage Differentials." Western Economic Association Conference, Los Angeles, June 1977.

"The Economics of Aging: Medical Care." Presentation and panel discussion, Washington State Public Health Association Conference, Ocean Shores, Washington, October 1977.

"The New Technology: Economic and Policy Issues." Tax/X Center for Health Planning Workshop, Seattle, Washington, October 1977.

"Hospital Classification for Prospective Reimbursement." Department of Health Services Seminar Series, University of Washington, January 1978.

"The Regulation of Hospital Reimbursement." Western Economics Association Meetings, Honolulu, June 1978.

"Grouping Hospitals for Prospective Reimbursement." California Health Facilities Commission, Sacramento, August 1978.

Panel Discussant, APHA Meeting, Los Angeles, October 1978.

"National Health Insurance." Womens' Health Care Professionals Meeting, May 1979.

"National Health Insurance: Issues and Problems." Regional Conference of Nurses, Fred Hutchinson Cancer Research Center, November 1979.

"If the Answer Isn't Regulation, What is it (Or Might it be)?" University of Washington, MHA Alumni Association Annual Meeting, April 1980.

"Health Economics." Group Health Cooperative of Puget Sound, January 1982.

"The Role of Antitrust in Health Economics." Western Network Health Care Executive Program, Berkeley, August 1983.

"Changes in Co-insurance and Deductibles and Demand for Psychiatric Service" with R. Scheffler et al., APHA meetings, Dallas, November 1983.

"Medicare Hospital Reimbursement: Impact of DRGs." Western Gerontological Society, San Francisco, November 1983.

"Demand for Outpatient Mental Health Services in a Heavily Insured Population." American Economic Association meeting, San Francisco, December 1983.

"Determinants of Inpatient Mental Health Use in a Heavily Insured Population." Conference on Mental Health Economics, NIMH, Berkeley, September 1984.

"The Impact of Financing on Health Services Delivery." Conference on Health Care Policy, Berkeley, August 1984.

"DRG-based Reimbursement: Concepts and Organizational Outcomes." Faculty Roundtable on Health Care Financing, Berkeley, February 1984.

"Demand for Mental Health Care in a Heavily Insured Population." Department of Health Services seminar series, October 1984.

"Managed Health Care in Washington State Health Policy." Seattle Chamber of Commerce, November 1984.

"The Changing Environment in Health Care Policy." Group Health Cooperative of Puget Sound continuing education program, 1985.

"Commercialism in Health Care: Are We Losing our Soul?" University of Washington MHA Alumni Day, May 1985.

"The Rural Hospital Project." Washington State Hospital Association Rural Hospital Annual Meeting, Chelan, Washington, June 1985.

"Current Issues in American Health Policy." Thirty-minute television program broadcast on Cablearn.

"Anti-trust in Health Care: The Case of Arizona vs. Maricopa County Medical Society." U.S. Department of Justice Anti-Trust Division, Washington D.C., August 1985.

"Changing Health Policy Environment: A Positive Response." Washington State Public Health Association Annual Meeting, September 1985.

"Health Policy and Economics." Seattle Association of Women Economists, September 1985.

"Certificate of Need: Background and Issues." Testimony before Human Services and Corrections Committee, Washington State Senate, September 1985.

"The Health Policy Analysis Program History and Issues." Departmental seminar, Fall 1985.

"Changing Payment Systems and Cost Shifting." Panel moderator, Innovations and Alliances '85 Conference sponsored by the Puget Sound Health Systems Agency, November 1985.

"Health Care Markets and Competition." Presentation to the Legislative Conference on Certificate of Need, November 1985. Sponsored by the Washington State Health Coordinating Council.

"Social Management of Risk." Department of Health Policy and Management, University of Massachusetts at Amherst, December 1985.

"Medicare Financing of State Veterans Homes." Testimony before Washington State Legislative Budget Committee, January 1986.

"Health Economics in a Changing Environment." Alumni Association, School of Business of the University of Colorado at Denver, February 1986.

"Economic Overview of the Health Care Industry." College of Medical Education, Medical Society of Pierce County, March 1986.

"Health Care in the '80s: A Forward Look." St. Joseph Health System strategic planning meeting, May 1986.

"The Uninsured in Washington." Testimony before the Washington Health Project Commission of the Washington State Legislature, July 1986.

"Changing Health Policy in a Changing Environment." Testimony before Washington State Senate Committee on Human Services and Corrections, July 1986.

"Allied Health Professions in Public Policy," Seattle Community College Conference for Allied Health, September 1986.

"Rural Health Services in the WAMI Region," American Public Health Association Annual Meeting, Las Vegas, Nevada.

"Washington Health Policy," American Business Women, Seattle Chapter, October, 1986.

"The Uninsured and the McPhaden Commission," Presentation to the University of Washington Hospitals, November 1986.

"The McPhaden Commission and Managed Care for the Indigent," presentation to the American College of Health Executives, Seattle chapter, November 1986.

"Health Insurance for the Uninsured" presentation to the Stanford Research Institute Conference on Private Sector Involvement in Health Care, Palo Alto, California.

"Prospective Payment for Physicians," Society of Anesthesiologists Annual Seafair Meeting, July 1987.

"Health Care Access," Secretary's Seminar in Health Policy, April 1987.

"Health Policy in the 1990's," Washington State Nurses Association 1987.

"Financial Status of Rural Hospitals," WSHA Rural Hospital Workshop, Chelan, July 1987.

"Mandated Benefits in Perspective," Symposium sponsored by State Health Coordinating Council, November 1987, Seattle.

"Rural Health: Issues and Policies," WAMI Legislative Conference, December 1987.

"Prenatal Care in Washington," presentation to board of Children's Hospital and Medical Center, January 1988.

"Financial Issues of the Elderly," Aging and the Elderly Review Course, sponsored by UW School of Medicine, February 1988.

"An Evaluation of Prenatal Care in Washington," Rural Health Strategies Conference, Spokane, March 1988.

"Obstacles to Service Delivery: A Response," The Duncan Seminary, April 1988.

"The Economic Environment Facing Rural Hospitals," Rural Health Policy Commission, Washington State Legislature, May 1988.

"Geriatrics Financing Options,: Economic Considerations in Geriatric Oral Health Care, Symposium, Case Western Reserve, May 1988.

"Health Policy Choices for the 1990's: What Can We Afford?", testimony before Health Committee, Washington State Senate, June 1988.

"Legislative Strategies for Uncompensated Care," Sisters of Providence, January 1989.

"Policy issues for the Uninsured: The Washington Basic Health Plan," seminar for Department of Community Dentistry, April 1989.

"The Basic Health Plan: A Tale of Great Expectations," Seminar for the Department of Health Services, Spring 1989.

"The Public Benefit in Public Health," Snohomish Health District, July 1989.

"Washington's Basic Health Plan," American Public Health Association Meetings, October 1989.

Panel Moderator, Employee Benefits Planning Association Annual Meeting, May 1990.

"Measuring the Uninsured," Association for Health Services Research Meeting, June 1990.

Panel Moderator, American College of Health Executives, June 1991.

"Health Policy Issues of the 1990s," Horizon House, Seattle, WA, October 1991.

"Health Policy and Health Care Reform," Seattle Women Economists, Seattle, WA, October 1991.

"Issues of Biased Selection in the Basic Health Plan," School of Public Health, University of Minnesota, Minneapolis, MN, March 1992.

"The Black Hole Theory: Selection in Washington's Basic Health Plan," Department of Health Services, University of Washington, Seattle, WA, April 1992.

"Health Care Reform from the Consumer's Perspective", Medical Managers' Association, Seattle, WA, April 1992.

"Health Care Reform: A Marketing Perspective", Medical Marketing Association, Seattle, WA, May 1992.

"Health Policy Lessons from Abroad," University of Puget Sound Health Lawyers Conference, Seattle, WA, May 1992.

"Health Care Reform: Tempest in a Teapot?", Department of Economics External Steering Committee, Seattle, WA, May 1992.

"Evaluation Update", Basic Health Plan Advisory Council, Seattle, WA, June 1992.

"The Federal Reserve Board: Health Care Analogy?", Washington State Hospital Association Board of Directors, Seattle, WA, June 1992.

"Health Care Reform Issues and Alternatives," Washington State Osteopathic Association, Blaine, WA, June 1992.

"Governor Candidates: Health Care Reform Platforms" (panel moderator), Patient Accounts Managers Association, Bellevue, WA, June 1992.

"Health Care Reform: Tempest in a Teapot?" University of Washington Board of Regents, Seattle, WA, July 1992.

"Fifty Paths to Reform" Conference sponsored by Indiana University School of Medicine, Indianapolis, October 1992.

"The Future of Health Care," Virginia Mason Continuing Education Program for Nurses, Seattle, March 1993.

"Health Care Reform: History and Future" Conference sponsored by Business and Professional Institute, Seattle, May 1993.

"Health Care Reform: What's in Store?" Washington Neurological Association of Neurological Surgeons, Annual Meeting, Chelan, June 1993.

"Revolution, Reform, and Research: The University and the 3R's," School of Public Health & Community Medicine Visiting Committee, November 10, 1993.

"Managed Care in Perspectives: Where Are We and How Did We Get Here?," Washington State Chest Conference Lung Day, January 1994, Leavenworth, WA.

"The Future of Health Care Reform," Methow Valley Speaker Series, Winthrop, WA, October 1994

"Health Care and Ecological Economics," Lakeside School, Seattle, WA, November 1994.

"Report of the Task Force on Medical Savings Accounts," Health Services Commission, Olympia, WA, December 1994.

"Overview of the Performance of the U.S. Health System," with Aaron Katz, Senate Health and Long Term Care Committee, Olympia, WA, January 1995.

"Lessons from the Basic Health Plan Evaluation," Group Health Center for Health Studies, Seattle, WA, March 1995.

"Health Care Economics in a Rural Environment." Fairbanks Memorial Hospital, Fairbanks, AK. April 1999.

#### **VIDEO PRESENTATIONS**

Washington Health Choices video project, Puget Sound Health Systems Agency, 1986.

## **PROFESSIONAL ACTIVITIES**

### **CONSULTING**

Member of site visit team and proposal review for study of Veterans Administration Hospital, New Haven, Connecticut, Veterans Administration, January 1977.

Project report review for Arthur Andersen study of Hospital Based Physicians, July 1977. University Hospital Study of Case-Mix Related Costs, 1977-1978.

Department of Social and Health Services, State of Washington, Consultant in Nursing Home Suit, 1978.

California Health Facilities Commission, 1978-1979.

Health Care Financing Administration, Study of Implementation of 223 Limits, 1979.

Development and presentation of ASTI course on rate regulation with Jay Glasser (University of Texas) and Frank Baker.

Blue Cross of Louisiana, Hospital Classification for Prospective Reimbursement, Summer 1981.

Blue Cross of Louisiana, helped develop hospital classification system for Louisiana hospitals, Summer 1981.

Commission on Professional and Hospital Activities, Economies of Scale project funded by Health Care Financing Administration, 1982-1983.

Hogan and Hartson, New York State Nursing Home suit, September 1982.

DRG Waiver Proposal, Hospital Council of Northern California, Summer, 1984.

Texas Department of Mental Health and Mental Retardation, Alternative prospective financing schemes, Winter 1985.

Bennett and Bigelow, Certificate of Need Appeals, 1985.

Office of the State Attorney General, State of Washington, Price fixing in Physician Controlled Insurance Companies, 1984-85.

Washington State Hospital Association, reimbursement regulation issues, 1986.

Overlake Hospital, certificate of need application, 1986.

American Medical Research Review Committee, workshop presentation for national PRO organizations, Washington, D.C. 1987.

Sisters of Providence, Legislative Strategies Project, 1989.

Snohomish Health District Public Health Funding Project with Arthur Andersen, 1989.

### COMMUNITY SERVICE

Assisted Puget Sound Health Systems Agency on grouping hospitals for planning purposes, Summer 1980.

Assisted Virginia Mason Hospital to clarify case-mix classification system, Summer 1980.

Group Health Cooperative of Puget Sound, planning committee member, 1980-1981.

Member, Citizens Forecast Committee, Seattle City Light, 1982-1983.

The Mason Clinic, Coping with Prospective Payment.

Puget Sound Health Systems Agency, Planning Committee for Conference on Managed Health Care, 1985.

Washington State Public Health Association, conference program planning committee.

Washington State Legislature, 1985-87:

- study of the state's role in public health, Joint Select Committee on Public Health
- certificate of need, House of Representatives staff
- financing alternatives for waste clean-up, Parks and Ecology staff
- financing of services for developmentally disabled children, Department of Developmental Disabilities
- sunset reviews of midwifery, drugless healers, chiropractors
- Chair, Technical Advisory Committee A to the Washington Basic Health Project Commission
- Public Health Policy Task Force, Washington State Senate
- Miscellaneous testimony on health policy issues, Washington State Legislature
- Prenatal Care Program Evaluation, Office of Parent and Child Health, 1986-87

Washington State Department of Justice Novack Commission on Tort Reform, 1987-88.

Advisory Committee to the Washington Rural Health Committee, Washington State Legislature.

Panel Chair, Health Systems Resources Legislative Conference, December 1987.

Facilitator, Washington State House of Representatives Conference on Long Term Care, 1987.

Consultant, Legislative Budget Committee Sunset Review of Hospital Cost Commission.

Member, Technical Advisory Committee to Rural Health Policy Commission, Washington State Legislature, 1988.

Consultant, Department of Labor and Industries, 1989.

Member, Task Force on Medical Savings Accounts, Washington Health Care Commission, 1994.

Consultant, St. Clare Hospital, Lakewood, Wa. 2001.

## **TEACHING**

Executive Program in Health Administration, University of Colorado (Denver), Program Evaluation Course, 3 credits, 100% responsibility, 25 students, 1989.

Executive Program in Health Administration, University of Colorado (Denver), Health Policy and Economics Course, 3 credits, 100% responsibility, 15 students, 1991.

Healthcare Management Institute, 2-day Health Economics seminar for Mercy Hospital physicians, San Diego  
100% responsibility, 30 students, 1992.

Management Education and Development Series, American College of Medical Practice Executives, 2 day Health Economics module, Marshfield, WI, November 1994.

Executive Program in Health Administration, University of Colorado (Denver), Health Policy and Economics Course, 3 credits, 100% responsibility, 11 students, 1993.

Executive Program in Health Administration, University of Colorado (Denver), Health Policy and Economics Course, 3 credits, 100% responsibility, 10 students, 1995.

## **FUNDED RESEARCH IN PROGRESS**

"State Planning Grant on Access to Health Insurance." Co-investigator. Aaron Katz and Susan Marquis, PI's. \$852,829. Washington State Office of Financial Management. July 2001 – February 2002.

"Community Health Tracking Study." Co-investigator. Aaron Katz, PI. \$ July 2000 – March 2002.

"Home Care Research Initiatives Grant: National Study of Home Care - Assisted Living Connection." Rosalie Kane, PI. The Robert Wood Johnson Foundation. (consultant)

"Multi-State Evaluation of Dual Eligible Programs." (subcontract) Robert Kane, PI. \$ 8,635. Health Care Financing Administration.

#### **RESEARCH PROPOSALS PENDING**

"Insurance Financing of Integrated Medicine." Co-investigator. Bill Lafferty, PI. Submitted to NIH. \$1,050,000. July 2001 – June 2004.

#### **FUNDED RESEARCH: COMPLETED PROJECTS**

"A Review of Certificate of Need." Aaron Katz, PI. \$50,000. Joint Legislative Audit and Review Committee. Co-investigator.

"Crime Victims Compensation Program Evaluation," C.W. Madden and Aaron Katz, Co-PI's, \$50,000. Washington State Department of Labor and Industries.

"Managed Care Monitoring and Evaluation Project," C.W. Madden & Robert Crittenden, Co-PI's, Interagency agreement with Health Care Authority under Robert Wood Johnson Foundation Grant, \$75,000, 12/15/93 - 6/15/94

"Health Services Utilization of the Previously Uninsured," C.W. Madden, P.I. Subcontract to University of Southern Maine proposal to R.W. Johnson Foundation \$540,392. 11/91-2/94.

"Issues in Hospital Classification and Reimbursement," T.D. Klastorin and C.A. Watts, Co-PIs, Health Care Financing Administration, \$422,223, 1981.

"A Study to Develop and Test Measures of Case Mix Complexity for Hospitals", T.D. Klastorin and C.A. Watts, Co-PI's, (subcontract to CPHA) Health Care Financing Administration, \$50,000, 1980.

"A Randomized Trial of Liaison Psychiatry in Primary Care," 10% (NIMH, economist)

"Health Insurance for the Low Income: An Evaluation," C.W. Madden, P.I. \$1.2 million 2 1/2 years, funded by NCHSR.

"Economic Analysis of Proposed Water Quality Standards," IPPM, \$20,000, 5% economist, funded by Washington Department of Ecology.

"Evaluations of Sound Care Plan", Washington Department of Social and Health Services, \$81,000, 1989 and 1991, C.W. Madden, P.I.

"Evaluation of Community Access Program," Washington Department of Social & Health Services, \$110,000, 1991. C.W. Madden, P.I.

"Evaluation of KPS Waiver Program", C.W. Madden, PI, Washington Department of Social and

Health Services, \$56,962, 1993.

"Sun Valley Forum," Robert Wood Johnson Foundation, \$80,000, 2/92-9/92.

"Health Care Cost Commission," \$79,000, State of Washington and Henry J. Kaiser Foundation, 6/90-12/92.

"Evaluation of Selective Contracting Program," Washington Department of Social and Health Services, \$55,663, 2/92-8/92

"The Cost of Foodborne Disease," C.W. Madden, P.I., \$25,000, USDA.

"Health Insurance for the Low Income: Competing Renewal," C.W. Madden P.I., \$1.2 million (direct), 2 1/2 years, AHCP, (3/91-9/93).

"Medical Risk Distribution Among Competing Health Plans," C.W. Madden and Margaret Stanley, Co-PI's, \$650,000, Robert Wood Johnson Foundation. 11/1/93 - 8/31/95.

"Healthy Options Statewide Evaluation," Aaron Katz, PI., 3% investigator, Washington Department of Social and Health Services, \$148,419, 2/1/95-6/30/95.

"An Evaluation of Medicaid Extension Demonstration in 3 states, (subcontract to Health Economics Research)," C.W. Madden, PI, Health Care Financing Administration, \$228,210 (total \$1,425,000), October 1992 - September 1997.

"Evaluation of the Worker's Compensation Managed Care Pilot Project," Tom Wickizer, PI, 5% investigator, Washington Department of Labor and Industries, \$347,145, 8/15/94-3/31/96.

"Effects of Physician Compensation on Physician Behavior," Doug Conrad, PI, 10% investigator, Robert Wood Johnson Foundation, \$624,048, 2/1/95-10/31/96.

"Community Snapshots," Aaron Katz, PI., 10% investigator, Robert Wood Johnson Foundation, \$167,613, 2/1/95-9/30/95.

"Washington State Health Services Commission," Aaron Katz, PI, 3% investigator, \$15,000, 4/1/94-6/30/95.

"An Evaluation of Medicaid Extension Demonstration in 3 states, (subcontract to Health Economics Research)," C.W. Madden, PI, Health Care Financing Administration, \$228,210 (total \$1,425,000) October 1992-September 1997.

"Hospital Diversion and Use of Psychiatric Hospitals," J. Semke PI, 1% consultant, NIMH, 10/93-9/98.

"Implementation of Diagnostic Risk Adjustment in an Employed Population," C.W. Madden, PI (25%), Robert Wood Johnson Foundation, \$1,053,719, 8/1/95-12/31/97.

"Health Status Based Risk Adjustment for a Medicaid SSI Population", C.W. Madden, PI. (10%),

Robert Wood Johnson Foundation, \$89,604, 8/1/96-7/31/97.

"Using the CCHC Classification to Assess Health Status for Risk Adjustment." C.W. Madden, PI. \$24,161. Children's Hospital and Medical Center.

"Use of CCCHC for Risk Adjustment of Capitation Payments." C.W. Madden, PI. \$59,990. Center for Health Care Strategies.

### **UNIVERSITY SERVICE**

Alternate, Committee on Legislative Affairs, 1988

Alternate, Graduate Program Coordinator, 1989

Faculty Senate representative, 1985-87

Chair, Ad Hoc Committee for Establishing Criteria for Progress of Research Associates, July 1988.

Chair, MHA Program Director Selection Committee 1990

Member, Faculty Affairs Committee, Graduate School of Public Affairs, 1989-90.

Member, Committee to Evaluate Health Services Chairman, 1989-90.

Member, Department of Health Services Curriculum Committee, 1990-91.

Member, Social Services Gateway Committee, Graduate School of Public Affairs, 1990-1994.

Member, MHA Birthday Party Planning Committee, 1991-92.

Member, Health Economics Committee Field Exam, 1992

Member, School of Public Health and Community Medicine Promotion and Tenure (Faculty Affairs) Committee, 1992-1994.

Member, Search Committee for Chair of Department of Health Services. 1994.

Chair, Task Force on MHA Policy Curriculum, 1995.

Member, Advisory Committee of the Center for Medical Education Research, 1995.



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F A X C O V E R S H E E T

DATE: 4-2-02

TO: Rep. Fred Dyson

COMPANY: \_\_\_\_\_ FAX: \_\_\_\_\_

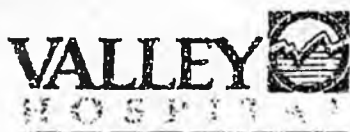
FROM: S. Ripley PHONE: 907-352-2860  
Valley Hospital FAX: 907-352-2865

Number of pages including cover sheet: 4

**Subject:**

Please accept this written response  
from Valley Hospital to your questions  
posed on 3/28 during public testimony  
for HB 407. Thank you.

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## MEMO

**TO: Representative Fred Dyson, Chair, House HESS Committee**

**FROM:  George Larson, CEO, Valley Hospital Association**

**RE: Your questions regarding Valley Hospital rates and not-for-profit status**

Per your questions to Elizabeth Ripley, Valley Hospital spokesperson, at the March 28 HESS committee meeting, please consider the following response. In your first question, you asked if a level playing field were possible when for-profit healthcare institutions pay taxes and not-for-profit hospitals do not. As a not-for-profit hospital association, VHA feels a great obligation to provide benefit to the community that exceeds the amount VHA would have paid in local, state and federal taxes.

Community benefit can be measured by the hundreds of thousands of dollars VHA contributes in "charity care" to those who cannot afford to pay for services rendered. The Mat-Su community benefits from the substantial monies VHA writes off in uncollectable accounts, discounts, and adjustments that number in the millions of dollars annually. VHA provides many services like health education and promotion, for which reimbursement does not equal the cost to provide those services.

We invest 10% of our net revenues in excess of expenses back into the Mat-Su Borough community through our Healthy Communities Program. This Healthy Communities Program makes small community grants to local organizations and funds programs throughout the Mat-Su Borough that help to raise health status of Valley residents. Nationwide, most hospitals invest less than one-percent back into the community, and Valley Hospital has been recognized for its leadership in this area. In the final analysis, we are confident that VHA gives back much more than the amount it would have paid in taxes.

Your second question asked about Valley Hospital's rates and if we charge the same rate for the same services to all financial classes. We do offer preferred provider discounts to organized groups in return for that group's guarantee that payment will be made for services provided to a specific population segment that typically numbers in the hundreds or thousands of people. Patients without insurance do not have the benefit of negotiating for hundreds or thousands of people. Still, we offer them a four-percent discount up front by paying at the time of service for both inpatient and outpatient care.

While all for-profit and not-for-profit institutions construct these preferred provider agreements with insurance brokers and the state and federal government, they do not universally extend such a generous discount option to patients without any form of insurance. In addition to this, Valley Hospital offers "self pay" clients payment plan arrangements that are interest free. In 2001, for self-pay billed charges, Valley Hospital received approximately 15 cents for every dollar billed. Of total billed charges, we annually write off seven percent in bad debt and two percent through our aggressive charity care program. This unreimbursed care totaled \$3,974,000 in 2000 and \$5,501,000 (unaudited) in 2001.

If you have further questions or would like to discuss Valley Hospital and our position on the CON, please do not hesitate to contact me at 907-352-2860.



## MEMO

**TO: Representative Fred Dyson, Chair, House HESS Committee  
Members of House HESS Committee**

**FROM: George Larson, CEO**   
**Valley Hospital Association**

**RE: Written Testimony for House Bill No. 407**

For the record, Valley Hospital Association is against the proposed population delimiter in House Bill No. 407 and Senate Bill 256. Valley Hospital serves one of the only large communities in the state that would be affected by this proposed population delimiter for the Certificate of Need process.

Valley Hospital supports other measures in these bills, including the following:

- Leaving the CON at the \$1,000,000 level
- Replacing facilities at the same site or in the same community as long as no new category of health services is provided and the existing facility is not used for other health services without a CON
- Adding time requirements and review standards for the CON department to process CON applications

We acknowledge the benefits of fair competition, and assert that this proposed delimiter does nothing to support a level playing field. We are particularly concerned about the establishment of "medical boutiques" (such as a free-standing imaging or surgery center) that limit services to those without third party insurance, thereby "cherry-picking" most of the paying customers. The demography and geography of Alaska limit the effectiveness of unregulated competition as a means of ensuring socially appropriate supply and demand of health care services.

To put this "cherry-picking" in perspective, the Mat-Su Borough has one of the highest rates of Medicaid patients, per capita, of any borough in the State of AK. Medicaid is the fast growing "payer segment," along with "self-pay"—those that do not have any insurance. In the last three months, Valley Hospital's "self-pay" financial class has doubled from eight percent to 12% of our payer mix. In the next five to 10 years, we expect our Medicare payer segment to double from six to 12 percent of our population. In Mat-Su, there are already private providers that do not accept or limit the number of Medicaid or Medicare patients that they see. Based on what is already happening, we cannot assume that these "medical boutiques" will treat patients in these payer groups that do not pay 100 cents on the dollar.

Valley Hospital is legally and ethically bound to serve all patients that walk through our doors, regardless of ability to pay. Under EMTALA, Valley Hospital cannot turn anyone away or discharge him or her due to financial class. A "medical boutique" does not operate under the same regulations and may in fact limit customers of a particular payer status (Medicaid, Medicare or self-pay).

Valley Hospital is a private business, a not-for-profit enterprise, and receives no assistance from the Mat-Su Borough government, which has limited health powers as a second class borough. Valley Hospital competes directly with the Anchorage providers (Alaska Regional and Providence). Over 16,000 Valley residents commute to Anchorage for work Monday through Friday. Surveys conducted by Valley Hospital show that most of these commuters receive their healthcare in Anchorage and use Anchorage providers. Over the last five years, Valley Hospital has made between 1.5 and 2.5 million dollars in net revenues. As you can see, Valley Hospital is in a competitive environment.

At Valley Hospital, our board members and administrators take seriously the intent and spirit of the code. We invest 10% of our net revenues in excess of expenses back into the Mat-Su Borough community through our Healthy Communities Program. This Healthy Communities Program makes small community grants to local organizations and funds programs throughout the Mat-Su Borough that help to raise health status of Valley residents. Nationwide, most hospitals invest less than one-percent back into the community, and Valley Hospital has been recognized for its leadership in this area.

In addition, Valley Hospital reinvests the remaining 90% of its revenues back into capital equipment, facilities and staffing to remain competitive and viable. Each year, Valley Hospital strives to donate one percent of its net revenues to charity care. This, coupled with uncollectible accounts, adds up to millions of dollars annually in unreimbursed care. This unreimbursed care totaled \$3,974,000 in 2000 and \$5,501,000 (unaudited) in 2001.

In summary, Valley Hospital supports keeping the Certificate of Need at a \$1 million threshold for equipment and raising the CON to a \$2 million threshold for building, so long as any bill altering the CON also supports the following criteria:

- All providers, including private physicians, must meet the terms of the CON.
- All providers must provide care for all financial classes, and their payer mix must reflect the payer mix of the locale within which they operate. (Note: the current CON bureaucracy at the State could track this.)
- All expenditures, whether they be for capital, equipment, operational lease, or bricks and mortar, must fall under this \$2 million threshold.

With such great controversy over this proposed amendment to the CON, we recommend that the legislature establish a working group comprised of providers and legislators to examine the entire CON process. Valley Hospital remains willing to work with interested parties and the State of Alaska to improve the CON process in order that it respond to the evolving needs of the health care environment in Alaska.

## Compilation of Comments on the Failure of CON Laws

Excerpted from "*BEYOND HEALTH CARE REFORM: RECONSIDERING CERTIFICATE OF NEED LAWS IN A MANAGED COMPETITION SYSTEM*"

By PATRICK JOHN MCGINLEY

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CON laws evolved from the health care reforms of the 1940s and were heavily promoted well into the 1970s by health care providers, who found CON effective in sheltering their businesses from the costly effects of a competitive marketplace. Congress mandated CON in 1974, but quickly repealed the mandate when CON failed to lower the nation's health care costs.

"In one comparison of health care prices and expenses, it was shown that such prices and expenses are actually higher in areas with CON regulations than they are in areas without CON."<sup>[1]</sup> In fact, national hospital care expenditures increased from \$52.4 billion when Congress enacted the 1974 National Health Act to an estimated \$230.1 billion in 1989.<sup>[2]</sup> Today, Americans are spending nearly a trillion dollars annually on health care.<sup>[3]</sup> In searching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering health care costs.<sup>[4]</sup> CON "has elicited a remarkable evaluative consensus—that it does not work."<sup>[5]</sup>

CON, in addition to failing to decrease national health care expenses, was having detrimental effects on the provision of health care in local communities. The effect of CON on local communities was perhaps best related to Congress by the words of Representative Rowland of the Eighth District of Georgia. Representative Rowland recognized that CON appeared to be a good idea in theory, yet in reality failed to control health care costs and was often insensitive to community needs. ("At first glance, the idea [of certificate of need] may have looked pretty good. In practice, however, the effect of certificate-of-need on health care costs has been dubious, at best. And the program has certainly been insensitive in many instances to the true needs of our communities.")<sup>[6]</sup>

One may question the wisdom of continuing any form of state regulation that failed to produce its desired goal when implemented nationwide.<sup>[7]</sup> As the review of Congress's intent indicates, CON had one goal—to save money. However, in those states which retained their CON laws, the retention was often supported by new and creative justifications, many of which were unrelated to saving money. Commentators, in their traditional role of explaining the reason behind events, have set forth many justifications explaining why states have kept the same old CON laws.<sup>[8]</sup> All these justifications, however, are the crafty work of commentators, and not the motivation of state legislatures. No state legislature has codified any of these new justifications as legislative intent.<sup>[9]</sup> These justifications should therefore carry little weight in a proper analysis.<sup>[10]</sup>

Where certificate-of-need laws limit resources effectively, the owners of existing facilities are in a seller's market. They can charge inflated prices for their facilities,..... [C]ertificate-of-need laws will continue to raise health care costs by restricting the entry of cost-effective providers into the market.[11].

1. Mark E. Kaplan, Comment, *An Economic Analysis of Florida's Hospital Certificate of Need Program and Recommendations for Change*, 19 FLA. ST. U. L. REV. at 487 (1991).
2. *Id.* at 487 n.102.
3. Clark C. Havighurst, *Contract Failure in the Market for Health Services*, 29 WAKE FOREST L. REV. at 47. (1994).
4. One author contends that the proper evaluative analysis is not whether certificate of need succeeded in lowering the nation's health care costs, but whether it thwarted the rate of increase in the nation's health care costs. See Kaplan, *supra* note 1, at 487. That author concedes, however, that certificate of need is a failure even under his alternative analysis. *Id.*
5. *Id.* (quoting Lawrence D. Brown, *Common Sense Meets Implementation: Certificate-of-Need Regulation in the States*, 8 J. HEALTH POL., POL'Y & L. 480, 481 (1983)).
6. 134 CONG. REC. H9455-01 (1988)
7. For legislators, wisdom can sometimes fall prey to lobbyists. For example, the Texas Medical Association was instrumental in reinstating certificate of need laws after the Texas legislature repealed the regulations. See *Statelines—Texas: Certificate-of-Need Program Reinstated*, 1 AMERICAN HEALTH LINE, June 16, 1992. In New Jersey, a coalition of twenty urban and teaching hospitals demanded that certificate of need laws not be repealed, warning that deregulation could force hospitals out of business, and stating that they were "concerned there is a push to a deregulated environment." *Statelines—New Jersey: Many Hospitals Fear Deregulation*, 1 AMERICAN HEALTH LINE, Nov. 19, 1992. Likewise in Georgia, the Atlanta Health Care Alliance says it has "supported the certificate-of-need law and health-planning regulations . . . . Duplicative, unnecessary health-care services have been very costly to our members." *Access, Quality, Cost—Cost Containment: Regulation "Back into Vogue"*, 1 AMERICAN HEALTH LINE, May 11, 1992. See also Clark C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 VA. L. REV. 1143, 1148-51 (1973) [hereinafter Havighurst, *Regulation by CON*], at 1216 (noting that "avoidance of 'duplication' is of course consistent with a cartel's preference for minimizing competition"). Hospital lobbyists demand the protection of certificate of need, because "business coalitions . . . see planning as a way to control costs for their members." *Access, Quality, Cost — Cost Containment: Regulation "Back into Vogue"*, 1 AMERICAN HEALTH LINE, May 11, 1992 (quoting James Kimmey, Dean of the School of Public Health at St. Louis University).

Hospitals are aware that, instead of controlling costs (or "revenue" as seen from the hospital's perspective), certificate of need had the opposite effect. *See supra* part I.B.2. "Viewed in the light of possibilities for more fundamental changes in the market for insurance and health services, certificate-of-need laws may appear as conservative measures, designed to preserve the very institutions [that] create the problems to which they are addressed." *See* Havighurst, *Regulation by CON*, *supra* note 6, at 1156. Hospitals therefore fight to keep certificate of need alive.

8. *See generally* Kaplan, *supra* note 1; Maja Campbell-Eaton, Note, *Antitrust and Certificate of Need: A Doubtful Prognosis*, 69 IOWA L. REV. 1451, 1453 (1984); Scott D. Makar, *Antitrust Immunity Under Florida's Certificate of Need Program*, 19 FLA. ST. U. L. REV. 149, 150 (1991); Bruce Babbitt & Jonathan Rose, *Building a Better Mousetrap: Health Care Reform and the Arizona Program*, 3 YALE J. ON REG. 243 (1986); Norman Daniels, *Technology and Resource Allocation: Old Problems in New Clothes*, 65 S. CAL. L. REV. 225 (1991); Mark A. Hall, *Managed Competition and Integrated Health Care Delivery Systems*, 29 WAKE FOREST L. REV. 1, 2 (1994); Carl J. Schramm & Steven C. Renn, *Hospital Mergers, Market Concentration and the Herfindahl-Hirschman Index*, 33 EMORY L.J. 869, 881 n.30 (1984) ("[H]istorically, demonstrating 'need' has often been an easy task, and less than one-quarter of all proposed projects fail to win planning agency approval."). The Supreme Court has held that "need" is not an unconstitutionally vague standard in regulatory statutes; John A. Robertson, *Asking the "Woman Question" About Health Care Reform*, 3 TEX. J. WOMEN & L. 1 (1994); David M. Frankford, *Privatizing Health Care: Economic Magic To Cure Legal Medicine*, 66 S. CAL. L. REV. 1 (1992). Examples of new justifications for old certificate of need laws include curbing "excessive competition," solving a "moral hazard," rectifying "inadequate information," and eliminating "inefficient incentives." *See, e.g.*, Kaplan, *supra* note 1, at 479-84. The true reasons for retaining CON are far more pragmatic. *See supra* note 6.
9. *E.g.*, CODE OF ALABAMA §§ 22-21-260 to 278 (1994); ALASKA STAT. §§ 13.07.021-.111 (1995); CAL. HEALTH & SAFETY CODE §§ 437.10, 439.7 (1995); CAL. GOV'T CODE § 15438.1 (1994); CONN. GEN. STAT. §§ 19a-154 to 155 (1994) (licensing and budget review law); 16 DEL. CODE ANN. §§ 9301-11 (1994); D.C. CODE ANN. §§ 32-326 (1981); FLA. STAT. ch. 408 (1993 and Supp. 1994); GA. CODE ANN. §§ 31-6-1 to 70 (1994); HAW. REV. STAT. §§ 323D-1 to 54 (1989); IND. CODE ANN. §§ 16-29-1-1 to 16 (Burns 1994) (expiring July 1, 1996 pursuant to IND. CODE ANN. § 16-29-1-16); IOWA CODE §§ 135.621-.73 (1994); KAN. STAT. ANN. §§ 65-4802 to 4822 (1992); KY. REV. STAT. ANN. §§ 216B.010-.310 (Baldwin 1994); ME. REV. STAT. ANN. tit. 22, 301-24 (1994); MD. CODE ANN., HEALTH-GEN., 19-101 to 222 (1994); MICH. COMP. LAWS §§ 333.22201-60 (1995); MISS. CODE §§ 41-7-171 to 209 (1995); MO. REV. STAT. §§ 197.30-.65 (1995); MONT. CODE ANN. §§ 50-5-301 to 316 (1994); NEB. REV. STAT. §§ 71-5801 to 70 (1994); N.H. REV. STAT.

ANN. §§ 151-C:1 to 15 (1994); N.J. REV. STAT. §§ 26:2H-1 to 2I-39 (1994); N.C. GEN. STAT. §§ 131E-175 to 190 (1994); N.D. CENT. CODE §§ 23-17.2-01 to 15 (1993); OHIO REV. CODE ANN. §§ 3702.51-.60 (Anderson 1995); OKLA. STAT. tit. 63, 1-850 to 858 (1995); OR. REV. STAT. §§ 442.58-.86 (1992); 35 PA. CONS. STAT. §§ 448.701-.712 (1995) (expiring 1996); S.C. CODE ANN. §§ 44-7-320 to 460 (Law. Co-op. 1976); TENN. CODE ANN. §§ 68-11-101 to 125 (1994); VT. STAT. ANN. tit. 18, 9431-44 (1994); VA. CODE ANN. §§ 32.1-102.1 to 102.11 (Michie 1994); V.I. CODE ANN. tit. 19, 223 (1994); WASH. REV. CODE §§ 70.38.015-.920 (1995); W. VA. CODE §§ 16-2D-1 to 15 (1995)..

10. A proper analysis of certificate of need should focus on the benefits of a regulated bed supply. After all, the purpose of certificate of need regulations is to control the size and growth of the bed supply. *See* discussion *supra* parts II.A., II.B. Therefore, to properly evaluate certificate of need laws, the effect of CON bed supply controls should be measured against the resulting increase or decrease in health care prices.

Regulatory restraint on the growth of bed supply will result in somewhat higher prices than an unregulated marketplace would produce no matter how well the health care industry is regulated. Havighurst, *Regulation by CON*, *supra* note 4, at 1218. Certificate of need laws monitor only certain kinds of hospital costs, and therefore "may merely divert inflationary pressures and achieve no control." *Id.* In many instances, this diversion leads to a higher price for health care. For example, imagine two hospitals, one regulated by certificate of need, the other unregulated. Further imagine an unexpected increase in hospital wage costs. *Id.* (revealing that this type of event is rather common in the health care industry by stating that increases in hospital wages and "other types of cost increases . . . are equally likely to occur"). The unregulated hospital has the opportunity to add beds and thereby allocate the increase in wage costs over a greater number of patients, resulting in a smaller increase in health care cost per patient. *See id.* The regulated hospital, however, cannot add beds because of certificate of need regulations. *See id.* (implying that, when a hospital's bed supply is fixed, then its maximum revenue is fixed, even though maximum costs are not). The regulated hospital must allocate the increased cost to a smaller number of patients, resulting in a larger increase in health care costs per patient. In that case, a hospital would face increased costs because certificate of need laws do not regulate wages, yet the hospital would experience no increase in revenue because certificate of need has capped the hospital's maximum revenue. Certificate of need, therefore, can prove rather costly to individual patients.

11. Peter P. Budetti, *Public Policy Issues Surrounding Certificate of Need*, 1978 UTAH L. REV. at 44-45.

## **Additional comments on the Failure of CON and the value of Competition**

“Health facilities exist to serve the public. How is the public served by a virtual monopoly over this most critical of all public needs”? *Former Mississippi Governor Kirk Fordice, in an address to the Mississippi Legislature, 1999, from the Mississippi state web page ([www.govoff.state.ms.us/main/gc/gc020299.html](http://www.govoff.state.ms.us/main/gc/gc020299.html));*

“CON laws, born out of an effort to control cost, may actually increase health care costs by suppressing competition, as noted by Department of Health Executive Director Dr. Ed Thompson in his 1995 response to PEER questions. A Daniel N. Mendelson and Judith Arnold study, based on extensive empirical analysis of hospital costs, concluded that CON programs have not held down hospital costs. These researchers also found no evidence of increased costs in the initial twelve states that repealed CON requirements.”  
*Ibid.*

“According to the FTC complaint detailing the charges in this case, the [*ambulatory surgery center*] acquisition would violate antitrust laws by substantially reducing competition for outpatient surgery services in Anchorage. The market for these services is highly concentrated, having few competitors, and entry by new entities is difficult because of state certificate-of-need requirements, the complaint states. Thus, the FTC alleged, it is unlikely that, absent the divestiture required by the settlement, a new competitor could be established quickly enough to deter any anticompetitive behavior by Columbia/HCA. Moreover, the acquisition could increase the probability of collusion among remaining sources of outpatient surgery in the market and could, therefore, deny patients and others the benefits of competition based on price, quality and service for outpatient surgery services in Anchorage.” *Press release from the Federal Trade Commission, September 15 1995, as listed on the FTC web site ([www.ftc.gov/opa/1995/09/950915/columbia-mca.htm](http://www.ftc.gov/opa/1995/09/950915/columbia-mca.htm));*

FEDERAL TRADE COMMISSION ECONOMICS STUDY FINDS  
CERTIFICATE-OF-NEED REQUIREMENTS INCREASE HOSPITAL PRICES AND  
COSTS

Consumers Benefit from Hospital Competition

“Certificate-of-need (CON) requirements, which were intended to control health-care costs, have actually increased hospital prices by four percent, according to a study issued today by the Federal Trade Commission’s Bureau of Economics.” *Press release from the Federal Trade Commission, May 5 1987, from the web site ([www.ftc.gov/opa/1987/hospitals.txt](http://www.ftc.gov/opa/1987/hospitals.txt)):*

“In addition, the study found, hospital expenses are higher in states that have CON laws. According to the study, “There is no evidence that CON laws have resulted in the resource savings they were purportedly designed to promote.”” *Ibid.*

“The study also found that in areas where there are more independent hospitals, consumers get higher quality at the same price because of the increased competition. However, CON laws may be used to reduce the number of hospitals, thereby injuring consumers, according to the Bureau of Economics. “Therefore recent plans and decisions to repeal CON laws in some states should increase consumer welfare,” the study states.” *Ibid.*

“According to Federal Trade Commission Chairman Daniel Oliver, “Their findings concerning CON laws provide further support for my belief that government restrictions on competition are a major source of consumer injury.”” *Ibid.*

“Our regulatory treatment of ASCs recognizes the Department’s historical policy of promoting greater utilization of ASCs because of the substantial cost savings to Federal health care programs when procedures are performed in ASCs rather than in more costly hospital inpatient or outpatient facilities.” *U.S. Department of Health and Human Services, Federal Register, 11/19/99, (volume 64, number 223), page 38;*

“Many commenters noted that ASCs have saved Medicare hundreds of millions of dollars, forcing hospitals to become more competitive, because ASC payment rates are typically lower than hospital payment rates for the same procedures. Several commenters stated that ASCs foster patient access to care, particularly in medically underserved regions. Moreover, many commenters observed that patients generally prefer outpatient surgical care at an ASC to hospital care. .... We agree that ASCs can significantly reduce costs for Federal health care programs, while simultaneously benefiting patients.” *Ibid, page 40;*

“.....subsidies to promote the overall financial health of safety net hospitals are determined through often complex allocation mechanisms not directly related to the provision of services, and..... the demarcation of support for public health and specialty services versus care for the poor and uninsured is unclear. He suggests that in order to assure community access to vital public health and specialized services grants should be used to target, financial support for those services essential for community care.” *Christine Grant, Chairperson, Commissioner of Health and Senior Services, quoting Darrell J. Gaskin, in Report of the Certificate of Need Study Commission, New Jersey, February 2000;*

“Mr. Havighurst was very critical of CON and supports a totally free market approach to the development of health care facilities and services. He believes CON is poorly conceived and has been responsible for serious policy mistakes that actually increased costs in the health care system;” *Ibid, citing Clark Havighurst, Wm. Neal Reynolds Professor of Law, Duke University School of Law;*

“Mr. Sweeney basically supported deregulation of CON because of the difficulty in balancing market forces and a strong CON program which might limit entry into the market.” *Ibid, citing Raymond D. Sweeney, Executive Vice President, Healthcare Association of New York State (HANYS);*

“Ms. Dickson provided an historic overview and analytical analysis of CON. Her analysis indicated that CON does not reduce acute care costs...” *Ibid, citing Pamela Dickson, Senior Program Officer, Robert Wood Johnson Foundation.*

## Additional Comments on the Failure of CON Legislation

“A recent study by Georgia State University of 37 papers on CON concluded with this statement “Our review of the research literature indicates that Certificate of Need programs have not only failed to achieve lower hospital costs, but they may have contributed to higher costs, greater inefficiency and lower quality of care. Although there have been no major studies of CON laws in the last five years, the evolution of the healthcare delivery system has removed much of the rationale for these programs existence”.”.[1]

“Certificate of Need is based on the dubious economic theory that increased supply and competition will increase prices” [2]

“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 time-consuming and expensive process. Needless to say, the added 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 the 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.

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 the most.

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”.[3]

1. John Steen, Director of the State of Georgia Certificate of Need Program, “*Certificate of Need: A Review*”, from the “AHPA Net” web site of the American Health Planning Association, 2001.
2. Michael D. Turner, CATO Institute, Washington, D.C. “*Ending the CON Game*”, pg 1, The Heartland Institute: Intellectual Ammunition, Jan – Feb 1996, from the web site, [www.heartland.org](http://www.heartland.org), 2001.
3. Turner, supra note 2, page 1-2.

"The cost of applying for a CON can be considerable, exceeding \$100,000 for major projects. If litigation is required, the cost may reach \$300,000..."[4]

"If the (CON) process does not make a significant contribution toward cost containment and equitable distribution of health care resources, and it provides, as some critics suggest, an obstacle to improved health care, it may be that the CON requirements should be abandoned." [5]

"The enormous expenditure of time and money by both administrative agencies and health care providers in complying with the CON process substantially reduces any savings that might be attributable to it. For all its promise, CON review has resulted in the elimination of few projects. Of over 20,000 CON applications reviewed throughout the country between 1979 and 1981, only ten percent were ultimately disapproved." [6]

4. Roberta M. Ross, "*Certificate of Need for Health Care Facilities: A Time for Reexamination*", 7 Pace Law Review 491 (1987), from web site <http://php.iupui.edu/~healthw/chapqo~1.htm>
5. Ross, *supra* note 4, page 3.
6. Ross, *supra* note 4, page 3.

# HB407 Testimony

**Carl Wales**  
**2 April 2002**

4/2/2002

HB407 Testimony

CAW 1

# Statistics used

- The statistics used in this testimony are shown in accompanying material. The source of that information is shown in the material.

# Certificate of Need (CON) Process

- While I have not found a written history which I can quote to support this, it is my understanding that the CON process evolved initially as a requirement of the federal government in hopes that it would control health care costs.
- Many states have realized that it does not serve that purpose so that now 30 % of the states have no CON.

4/2/2002

HB407 Testimony

CAW 3

# CON Requirements

- Of the ten **least** densely populated states only two have a CON requirement. Of those two, one requires a CON only for counties with a population of over 100,000 and the other requires a CON only for long term care beds.
- Of the top 15 least densely populated states only four require the CON (the two above plus two more).

- Residents of states with high population densities have options/choices by virtue of having lots of facilities.
- This provides choice and drives efficiency in delivering health care.

- States with small populations need a “free market system” to foster choices and competition.
- Why is Alaska the only one in the top seven least densely populated states with a CON requirement?

4/2/2002

HB407 Testimony

CAW 6

# Myth

- “Non-profit” and “Not-for-profit” do not necessarily mean efficient operation of the organization.
- Many “Non-profit” and “Not-for-profit” organizations that are funded through charities are driven to greater efficiency because the donors may donate to other causes (donors have choices).
- Health care organizations (and other types of organizations) that have a monopoly are not driven to be efficient and provide the highest quality— they can exist, and continue to exist, and be inefficient, by virtue of their being the *only* choice no matter how bad the choice is.

# Carl Wales

- Resident of Fairbanks since 1993.
- I do not work for any part of the health care system.
- I do not own stock in or benefit in any way from the health care industry beyond being a patient.

# Accompanying material

- Spreadsheet showing state sizes and populations plus the calculations to determine population density and ranking.
- Chart of states requiring the CON taken from the Community Catalyst web site.

## Certificate of Need shown compared to Population and Size

Rank by Population	State	Population (2000 est.)*	Rank by Size	State	Size (Sq. miles of land**)	Pop Density	Rank by Density	CON	
48	Alaska	626,932	1	Alaska	670,374	1.10	1	Y	
51	Wyoming	493,782	9	Wyoming	97,105	5.09	2	N	
47	North Dakota	642,200	17	North Dakota	60,994	9.31	3	N	
46	South Dakota	754,844	10	South Dakota	77,122	9.79	4	N	
36	New Mexico	1,819,046	5	New Mexico	121,365	14.99	5	N	
39	Idaho	1,293,953	11	Idaho	82,751	15.64	6	N	
35	Nevada	1,998,257	7	Nevada	109,806	18.20	7	Y	18
38	Nebraska	1,711,263	15	Nebraska	75,898	22.55	8	Y	17
34	Utah	2,233,169	12	Utah	82,168	27.18	9	N	
32	Kansas	2,688,418	13	Kansas	81,823	32.86	10	N	
28	Oregon	3,421,399	10	Oregon	96,003	35.64	11	Y	
40	Maine	1,274,923	39	Maine	30,865	41.31	12	Y	
24	Colorado	4,301,261	8	Colorado	103,729	41.47	13	N	
20	Arizona	5,130,632	6	Arizona	113,642	45.15	14	N	
27	Oklahoma	3,450,654	19	Oklahoma	68,679	50.24	15	N	
33	Arkansas	2,673,400	27	Arkansas	52,075	51.34	16	Y	
30	Iowa	2,926,324	23	Iowa	55,875	52.37	17	Y	
31	Mississippi	2,844,658	31	Mississippi	46,914	60.64	18	Y	
21	Minnesota	4,910,479	14	Minnesota	79,617	61.79	19	N	
49	Vermont	608,827	43	Vermont	9,249	65.83	20	Y	
37	West Virginia	1,808,344	41	West Virginia	24,087	75.08	21	Y	
2	Texas	20,851,820	2	Texas	261,914	79.61	22	N	
17	Missouri	5,596,211	18	Missouri	68,898	81.21	23	Y	
23	Alabama	4,447,100	28	Alabama	50,750	87.83	24	Y	
15	Washington	5,894,121	20	Washington	66,582	88.52	25	Y	
18	Wisconsin	5,303,675	25	Wisconsin	54,314	98.75	26	N	
25	Kentucky	4,041,769	36	Kentucky	39,732	101.73	27	Y	
22	Louisiana	4,468,978	33	Louisiana	43,556	102.58	28	Y	

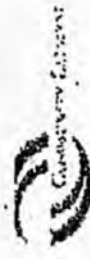
### Certificate of Need shown compared to Population and Size

26	South Carolina	4,012,012	40	South Carolina	30,111	133.24	29	Y	
41	New Hampshire	1,235,786	44	New Hampshire	8,969	137.78	30	Y	
18	Tennessee	5,689,203	34	Tennessee	41,220	138.02	31	Y	
10	Georgia	8,186,453	21	Georgia	57,918	141.35	32	Y	
11	North Carolina	8,049,313	29	North Carolina	48,718	165.22	33	Y	
14	Indiana	6,080,485	38	Indiana	35,870	169.51	34	Y	
8	Michigan	9,938,444	22	Michigan	56,809	174.94	35	Y	
12	Virginia	7,078,515	37	Virginia	39,598	178.76	36	Y	
42	Hawaii	1,211,537	47	Hawaii	6,423	188.62	37	Y	
1	California	33,871,648	3	California	156,973	217.16	38	Y	
5	Illinois	12,410,293	24	Illinois	55,593	223.40	39	Y	
6	Pennsylvania	12,281,054	32	Pennsylvania	44,820	274.01	40	N	
7	Ohio	11,353,140	35	Ohio	40,953	277.22	41	N	
4	Florida	15,982,378	26	Florida	53,997	295.89	42	Y	
45	Delaware	783,600	49	Delaware	1,955	400.82	43	Y	
3	New York	18,976,457	30	New York	47,223	401.85	44		
10	Maryland	5,296,486	42	Maryland	9,775	541.84	45	Y	
29	Connecticut	3,405,666	48	Connecticut	4,846	702.90	46	Y	
13	Massachusetts	6,349,007	45	Massachusetts	7,838	810.04	47	Y	
43	Rhode Island	1,048,319	50	Rhode Island	1,045	1003.18	48	Y	
9	New Jersey	8,414,350	46	New Jersey	7,418	1134.32	49	Y	19
44	Montana	902,195	4	Montana	145,558	6188.27	50	Y	
50	Washington, D.C.	572,059	51	Washington, D.C.	61.4	9316.92	51	Y	
				*Source: Almanac - U.S.; Department of Commerce, Bureau of the Census				Based on Community Catalyst 1999 chart	

<http://www.lpl.org/youth/stateknow/popchart.html>

## Certificate of Need shown compared to Population and Size

- |    |   |
|----|---|
| 17 | Only for long term beds                   |
| 18 | Only for counties over 100,000 population |
| 19 | Only for acute care hospitals             |



# Certificate of Need Chart

State	CON (Y/N)?	Oversight Agency	Change in ownership	Constructing a new hospital	Closing a hospital	Increasing servers	Increasing # of beds	Merge or consolidation	Limits # of acquisitions	Considers community benefits and/or level of indigent care before issuance	Public access to application	Public notice of application	Public hearing on application	Public able to appeal decision
Alabama	Y	State Health Planning and Development Agency	X	X			X				X	X	X	X
Alaska	Y	Department of Health and Social Services	X				X							X
Arizona	N													
Arkansas	Y	State Board of Health (Division of Health Facilities Services)	X	X			X							
California	Y	Office of Statewide Planning and Development	X	X									X	X
Colorado	N													
Connecticut	Y	Office of Health Care Access	X	X		X	X					X	X	X
District of Columbia	Y	State Health Planning and Development Agency	X			X	X				X			
Delaware	Y	Delaware Health Resources Board	X	X							X	X	X	X
Florida	Y	Agency for Health Care Administration	X	X										
Georgia	Y	Department of Community Health	X	X										
Hawaii	Y	State Health Planning and Development Agency	X	X		X	X						X	X
Idaho	N													
Illinois	Y	Health Facilities Planning Board	X	X		X	X				X	X	X	
Indiana	Y	The State Department	X	X										
Iowa	Y	Department of Public Health and Facilities Council	X	X		X	X			X		X	X	X
Kansas	N													
Kentucky	Y	Cabinet for Human Resources	X	X		X	X						X	X

Certificate is required for:



Certificate is required for:

State	CON (Y/N)?	Oversight Agency	Change in ownership	Constructing a new hospital	Closing a hospital	Discontinuing services	Increasing # of beds	Merge or consolidation	Limits of acquisitions	Considers community benefits and/or level of indigent care before issuance	Public access to application	Public notice of application	Public hearing on application	Public vote to appeal decision
Louisiana	Y	Department of Health and Hospitals	X	X							X	X	X	X
Maine	Y	Department of Human Services and Certificate of Need Advisory Committee	X							X	X	X	X	X
Maryland	Y	State Health Resources Planning Commission	X	X	X	X	X	X						X
Massachusetts	Y	Department of Public Health	X	X			X				X		X	X
Michigan	Y	Department of Public Health and Certificate of Need Commission	X	X										
Minnesota	N													
Mississippi	Y	State Department of Health	X	X								X	X	
Missouri	Y	Missouri Health Facilities Review Committee				X	X					X	X	
Montana	Y	Department of Public Health and Human Services									X	X	X	
Nebraska	Y	Department of Health and Human Services Regulation and Licensure												
Nevada	Y	Department of Human Resources	X	X							X	X	X	X
New Hampshire	Y	Health Services Planning and Review Board	X	X							X	X	X	
New Jersey	Y	Department of Health and Senior Services	X	X										
New Mexico	N													
New York	Y	Department of Health and Human Services	X	X									X	
North Carolina	Y	Department of Health and Human Services	X	X						X				

Community Catalyst

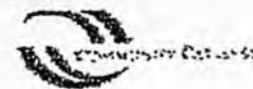


Certificate is required for:

State	CON Q/N?	Oversight Agency	Change in ownership	Constructing a new hospital	Testing a hospital	Decreasing servers	Decreasing # of beds	Merge or consolidation	Limit # of acquisitions	Considers community benefits and/or level of indigent care before issuance	Public access to application	Public notice of application	Public hearing on application	Public note to appeal decision
North Dakota	N													
Ohio	N													
Oklahoma	N													
Oregon	Y	Health Division of the Department of Health Resources	X	X										X
Pennsylvania	N													
Rhode Island	Y	Department of Health	X	X			X				X	X	X	X
South Carolina	Y	Department of Health and Environmental Control	X	X										X
South Dakota	N													
Tennessee	Y	Health Facilities Commission		X		X						X	X	X
Texas	N													
Utah	N													
Vermont	Y	Health Policy Council	X	X			X					X	X	
Virginia	Y	Department of Health	X	X								X	X	
Washington	Y	Department of Health	X	X								X	X	
West Virginia	Y	West Virginia Health Care Cost Review Authority	X	X		X	X				X	X	X	X
Wisconsin	N													
Wyoming	N													
Total: 51	35		18	29	4	11	15	0	0	8	10	19	25	16
Percentage	69%		35%	57%	8%	22%	29%	0%	0%	16%	20%	37%	49%	31%

Notes are on the following page

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Notes

1. For any change
2. Hearing not required, must be requested
3. CoN not needed if gave prior notice
4. All applicants must certify that they will provide uncompensated care (charity care and bad debt) for the next five years at a percentage equal to or greater than the previous two years
5. Hearing only for purchase or lease of hospital
6. Only for acquisition of a nonprofit health care facility
7. Referred to as "certificate of exemption"
8. CoN only needed for Comprehensive Care Beds
9. But may be exempt
10. Any affected person may appeal the decision
11. But, only in the case of lease arrangements
12. For change in bed capacity or services
13. DPH may hold a hearing, or applicant, state, or 10 taxpayers may request a hearing
14. CoN not required, but must give notice
15. CoN not required for hospitals
16. Hearing not required, must be requested, or Authority may schedule on own initiative
17. As of June 12, 1997, a CoN in Nebraska is only required when creating, relocating, or converting long term care beds
18. CoN only required for counties with a population less than 100,000 and for projects costing more than \$2 million
19. Only for acute care hospitals
20. New York does not have licenses or CoNs, it has "certificates" that encompass both licensing and CoN
21. CoN for long term care facilities such as nursing homes
22. Only for discontinuing obstetrical or maternity services

HESS Committee Information: 4-4-02

You've heard some interesting comments from hospital industry people. Much of what they've told you is misquoted or wrong. I'd like to address several of these issues.

1. **Hospital Claim** - Doctors engage in "cherry-picking", don't see Medicare, Medicaid and "self-pay" patients. **Truth:** At Tanana Valley Clinic, 24% of our patients are Medicare or Medicaid and 9% have no insurance at all. That means 30,000 Medicare and Medicaid patients each year and 11,000 patients annually without any insurance. We provided \$6.9 million worth of charity care to Medicare and Medicaid patients last year, and \$2.6 million care to patients with no insurance: these are the patients that the hospitals say we refuse to see. In addition, over the past 3 years, TVC provided nearly \$18 million in charity care. The hospitals want you to think that they are the only ones who provide charity care but the fact is that we provide nearly six million dollars each year. Also, the hospital's argument can easily be turned on its head. We aren't exempt from taxes as the hospitals are, so we can't continue to provide millions in charity care if we don't expand our community services, and if the hospitals are allowed to keep "cherry-picking" the patients with the best insurance.
2. **Hospital Claim:** patients suffer higher mortality rates in non-CON states. **Truth:** Fairbanks Memorial quoted a Florida study that covered only *cardiac surgery*, but the hospitals misapply this information and try to trick you into thinking that quality of care is lower in non-CON states. This is completely incorrect and is directly contradicted by a study of 1,000 hospitals, quoted in the "Journal of Health Politics, Policy and Law" in 1998 that clearly says "...*that states with more stringent CON policies or hospital rate-setting experienced higher mortality rates.*"(page 477 in Conover). A 1999 Washington state study of CON states "*The evidence is weak regarding the ability of CON to improve quality by concentrating volume of specialized services.*" ("Effects of CON and its Possible Repeal" page iii). In addition, a Northwestern University study of more than 200,000 patients in 45 states concluded that states with the most stringent CON

regulations had mortality rates 5 to 6 percent higher than states with less stringent CON regulations. (*Goodman and Musgrave, "Patient Power", 1992*) If anything, CON doesn't improve quality of care - it raises patient mortality rates.

3. **Hospital Claim:** If the CON law is modified, "This could very likely lead to catastrophic increases in costs Statewide, and perhaps even the closure of some of Alaska's most vulnerable rural hospitals" (March Fairbanks Memorial letter to legislators) **Truth:** In a 1993 article titled "Certificate of Need Revisited", health care expert Daniel Mendelson said "*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*". Then in 1998, Professor Conover made the following point about the 15 states that by then had then eliminated CON: "*States that lifted CON did not experience a rise in spending on hospital and physician services relative to those that retained it.*" (Conover, page 478). A third 1999 study (*Effects of CON and It's Possible Repeal, page 13*) noted that the financial effects of eliminating CON "...*have been insufficiently studied to determine if there are any persistent effects on cost*". Clearly the Hospitals scare tactics are absolutely wrong, as documented in three recent professional studies. In fact it's just the opposite - Conover quotes a 1991 study on health care costs, stating "...*CON was associated with a 20.6% increase in hospital spending and a nine percent increase in other health care.*"
  
4. **Hospital Claim:** Eliminating CON will have such a severe impact on them that they will eliminate some of the less profitable services that they now provide - charity care will be eliminated (March Fairbanks Memorial letter to legislators). **Truth:** Conover's 1998 study said CON is linked to "...*increased hospital profitability...*" and "...*lifting CON had no impact on any of these dependent variables*". In other words, Conover shows that removing CON has no impact on hospital profitability, and will not lead to any decrease in charity care. The 1999 Washington study referenced above also notes "...*we found no studies that directly link CON with higher levels of charity care*" (*Effects of CON and Its Possible Repeal, page 23*). Clearly there is no evidence that eliminating CON

reduces charity care – this is another example of hospital scare-mongering that is contradicted by independent scientific research.

**Final Note:** Doctors throughout the country are being forced to limit or exclude the numbers of Medicare or Medicaid patients they see, because of the extraordinary low payments they receive for these patients – 27% for Medicare and 55% for Medicaid at TVC. In Seattle, hundreds of doctors have begun to close their practices to Medicare and Medicaid and many doctors are leaving the area (see Seattle PI article in 4/1/02 edition). At TVC, with our total 33% Medicare, Medicaid and “no-insurance” patients, we have been taking a terrible financial beating in recent years – doctors pay is down over 20% since last year. We have lost 11 doctors out of 26 in less than two years, in large part because they cannot pay their bills if they see 1/3 Medicare, Medicaid and “no-insurance” patients. We cannot continue to see anyone who presents themselves at our doors, as is our current policy, if we cannot cover our costs. Thus, if the CON law continues to guarantee the hospitals a monopoly over such services as ambulatory surgery, the 40,000 Medicare, Medicaid and “no insurance” patients TVC sees annually may be forced to go to the hospital for care and will become the responsibility of the community and the State. We do not want to see this happen, but you need to realize that the doctors of our community can not continue to carry this multi-million dollar charity care burden, while hospitals cut back their services to the poor and escape payment of any taxes in our community. TVC pays more property taxes than any other locally owned business in the Borough - the hospital pays none. We pay State corporate taxes – the hospital pays none. We will do our share, but our position is becoming tenuous.

Thank you. I'd be happy to answer any questions.

Brian Slocum

Administrator

Tanana Valley Clinic

(907) 459 - 3509

22-LS1389\O  
Lauterbach  
4/4/02

**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 repealed and reenacted to read:

5 (a) Except as provided in (c) of this section, a person may not, unless  
6 authorized under the terms of a certificate of need issued by the department, make an  
7 expenditure of

8 (1) any amount for

9 (A) construction of a skilled nursing facility or psychiatric  
10 hospital;

11 (B) an increase in the bed capacity of a skilled nursing facility  
12 or psychiatric hospital;

13 (C) conversion of a building or part of a building to a skilled  
14 nursing facility or psychiatric hospital;

1 (D) conversion of a bed in a health care facility to a psychiatric  
2 bed designated for care of a child under 21 years of age;

3 (E) conversion of the existing use of a bed in a health care  
4 facility to a new bed use other than new use as a psychiatric bed designated for  
5 the care of a child under 21 years of age if the existing use required a  
6 certificate of need at the time the use was established and the health care  
7 facility is located in the unorganized borough or in an organized borough with  
8 a population of less than 55,000 at the time of the proposed conversion,  
9 according to the latest reliable data approved by the Department of Community  
10 and Economic Development; or

11 (2) \$1,000,000 or more for

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

14 (B) construction of a health care facility other than a skilled  
15 nursing facility or psychiatric hospital, alteration of the bed capacity of a health  
16 care facility other than a skilled nursing facility or psychiatric hospital, or  
17 addition of a category of health services provided by a health care facility other  
18 than a skilled nursing facility or psychiatric hospital, if the health care facility  
19 is located in the unorganized borough or in an organized borough with a  
20 population of less than 55,000 at the time of commencement of activities,  
21 according to the latest reliable data approved by the Department of Community  
22 and Economic Development.

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

24 (c) Notwithstanding (a) of this section, a person who is lawfully authorized to  
25 operate [OPERATING] a health care facility [THAT IS AN AMBULATORY  
26 SURGICAL FACILITY] at a site may make an expenditure of any amount in order to  
27 replace the facility at the same site or relocate the services of that facility to a new  
28 site in the same community without obtaining a certificate of need as long as neither  
29 the bed capacity nor the number of categories of health services provided at the new  
30 site or in the new facility is greater, the percentage of beds designated for each  
31 type of use at the new site or in the new facility is not different from the

1 percentage of beds designated for that type of use at the old site or in the previous  
2 facility, and no new category of health services is provided at the new site or in  
3 the new facility. However, [NOTWITHSTANDING THE EXPENDITURE  
4 THRESHOLD IN (a) OF THIS SECTION,] a person may not use the site from which  
5 the health care facility relocated for another health care facility unless the person  
6 complies with the [AUTHORIZED UNDER A] certificate of need requirements of  
7 (a) of this section [ISSUED BY THE DEPARTMENT].

8 \* Sec. 3. AS 18.07.035 is amended to read:

9 **Sec. 18.07.035. Application and fees.** Application for a certificate of need  
10 shall be made to the department upon a form provided by the department and must  
11 contain the information the department requires to reach a decision about whether to  
12 issue the certificate of need [UNDER THIS CHAPTER]. Each application for a  
13 certificate of need must be accompanied by an application fee established by the  
14 department by regulation. The department shall, by regulation, set a time limit by  
15 which the department shall determine whether an application submitted under  
16 this section is complete and contains all of the information the department  
17 requires to reach a decision about whether to issue the certificate of need.

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

19 **Sec. 18.07.037. Public hearing required.** Except as provided in  
20 AS 18.07.071, the department shall hold a public hearing within a reasonable time  
21 after determining that an application under AS 18.07.035 is complete. By regulation,  
22 the department shall establish

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

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

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

30 \* Sec. 5. AS 18.07.043 is amended to read:

31 **Sec. 18.07.043. Standard of review for applications for certificates of need**

1 and applications to modify certificates of need [RELATING TO NURSING  
2 HOMES AND NURSING HOME BEDS]. (a) The department shall develop  
3 review standards for an application for a certificate of need, or for a modification of a  
4 certificate of need, issued under this chapter [FOR A HEALTH CARE FACILITY  
5 THAT IS A NURSING HOME OR HAS NURSING HOME BEDS].

6 (b) When determining whether to approve an application for a new  
7 certificate of need or to modify an existing certificate of need [IN DEVELOPING  
8 THE REVIEW STANDARDS UNDER (a) OF THIS SECTION], the department  
9 shall consider whether

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

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

18 (3) the project [ADDITIONAL NURSING HOME BEDS OR THE  
19 HEALTH CARE FACILITY] demonstrates consideration of the community, regional,  
20 and statewide needs [FOR NEW NURSING HOME BEDS];

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

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

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

31 (7) the sponsor has demonstrated cost effectiveness through