ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672

11145 SENATE HEALTH, EDUCATION & SOCIAL SERVICES

History of Concurrent (Competing) Certificate of Need Reviews

There have been only 6 concurrent reviews since the inception of the CON program in 1976. Only 8.2% of all applications since 1990 were reviewed concurrently. 7 AAC 07.060(a), states: "In the commissioner's discretion, the agency shall defer commencement of the review process for a period not to exceed 60 days after the determination that the application is complete to enable the state agency and the appropriate health systems agency to receive and consider concurrently applications from each person who has submitted a letter of intent... proposing an activity within the appropriate health service area which is similar to the activity proposed by the applicant." ***Key Points: A letter of intent must be in hand from a competing project in order for a concurrent review to be allowed and a competing application must be submitted within 60 days after the first application has been declared complete.*** The six concurrent reviews are:

1982	**Charter Medical Corporation submitted a CON to construct a $12.2 million 80-bed psychiatric/alcohol/drug abuse hospital in Anchorage. An application for a 34-bed, $3.4 million alcohol/drug hospital was received from Advanced Health Systems/Raleigh Hills. Comprehensive Care Corporation submitted a letter of intent for $5.5 million, 50-bed alcohol/drug treatment hospital but did not submit an application. Charter and Advanced Health Systems were approved.**
1982	**Providence Hospital submitted a CON application for an $80 million, 150-bed addition and Humana Hospital (now Alaska Regional) submitted a CON for a $21.6 million, 93-bed addition. The projects were approved, but reduced to 53 additional beds and 39 additional beds respectively.**
1985	**Heritage Place (Soldotna) and South Peninsula Hospital (Homer) submitted CON applications for 60 nursing home beds. Heritage Place was approved for 45 nursing beds and a shelled in space for 15 additional beds to be opened later when use increased. South Peninsula's request for 60 beds was denied.**
1985	**Camai Care Center, Palmer; Careage Nursing Center, Wasilla; and Cook Inlet Housing Development Corporation submitted CON applications for 90-bed nursing facilities. Cook Inlet Housing Development Corporation was approved to build a 60-bed facility and 30 assisted living beds at a cost of $8.8 million. This facility was named the Mary Conrad Center. Careage was denied, Camai Care approved, but was later denied a time extension due to lack of process.**
1995	**Fairbanks Memorial Hospital (FMH) submitted a CON application for outpatient services including ambulatory surgery, and Fairbanks Surgery Center (FSC) submitted a CON for a freestanding ambulatory surgery center. Only the surgery portion of the FMH CON was reviewed concurrently with the FSC CON. Both were approved. FSC was later denied due to lack of progress.**
1999	**Tanana Valley Clinic, Fairbanks Surgery Center, Inc. and Fairbanks Memorial Hospital submitted CON applications for 5 surgery suites and 4 procedure rooms costing $11 million. None of the applicants were approved.**

Attachment #3

Certificate of Need Questions & Answers

Question: What types of projects are required to submit a certificate of need application and go through the review process?

Answer: Any health care facility project that involves the expenditure of $1 million or more for construction, renovation or the purchase of new equipment, and any project, regardless of cost, that converts space into nursing home beds is required to submit a certificate of need application.

Question: Are there any types of "health care facility" projects that are currently exempt from the certificate of need program?

Answer: Projects are exempt from certificate of need if: 1) the project cost is under the $1 million threshold; 2) the project is for routine maintenance or routine replacement regardless of the cost; 3) the project is for specifically exempted Pioneer Homes, private physicians' offices, or dentists' offices; or 4) the project is not included in the definition of "health care facility."

Question: Will the definition of a "health care facility" change if HB 511 passes?

Answer: Yes. If HB 511 passes, two additional types of facilities will be added to the list of those projects that may be required to go through the CON process: 1) Residential Psychiatric Treatment Centers (RPTCs), and 2) independent diagnostic testing facilities.

Question: Are all projects exempt from certificate of need if they fall below the dollar threshold?

Answer: All projects that fall below $1 million are exempt from certificate of need except for space converted to nursing home beds, which must submit a CON application regardless of the cost.

Question: What are the components of the certificate of need (CON) process?

- Submission of a letter of intent - (includes who what, where, how large, the cost and timeline);
- Letter of intent (LOI) determination - a decision is made as to whether a CON is required;
- 60-Day wait - A CON application may be submitted 60 day after the LOI determination;
- Completeness Check - The application is checked for completeness, and more information is requested if the application is incomplete. The applicant has 60-days to submit information;
- Review Period - The analysis document must be submitted to the Commissioner in 90 days;
- Public Notice & Public Comment – Public notice is given at the beginning of a review and the public comment period runs concurrently with the review,
- Commissioner's Decision - The Commissioner makes the decision, which is published, and
- Appeal - The applicant has 30 days to appeal if dissatisfied.

Question: If I apply for a certificate of need, how long will it take for a decision?

Answer: Once your application is received and declared complete, a review document must be submitted to the Commissioner for a decision within 90 days. The Commissioner does not have a timeline to make a decision, but generally makes one in about two weeks.

Question: How much does it cost to prepare a certificate of need application?

Answer: That depends on the size of the project, its complexity and whether it is controversial. A rule of thumb is that a certificate of need application should not cost more than 1% of the total project cost with a maximum of $25,000. Health Facilities Planning and Development, a consulting firm that writes approximately 70% of all CON applications for facilities in Washington State and has done at least 4 applications in Alaska, charges approximately $15,000 per application, regardless of the size of the facility.

Attachment #2

Certifi' te of Need Thresholds B State - 2001			
State	Capital	Equipment	New Service
Alabama	$ 3,200,000	$ 1,500,000	All
Alaska	$ 1,000,000	$ 1,000,000	$ 1,000,000
Arkansas (LTC)	$ 500,000	N/A	All Home Health
Connecticut	$ 1,000,000	$ 400,000	All
Delaware	$ 5,000,000	$ 5,000,000	N/A
Dist. of Columbia	$ 2,000,000	$ 1,300,000	$ 600,000
Florida	None	None	All
Georgia	$ 1,155,881	$ 642,157	All
Hawaii	$ 4,000,000	$ 1,000,000	All
Illinois	$ 6,000,000	$ 6,000,000	All new, expansions
Iowa	$ 1,500,000	$ 1,500,000	$ 500,000
Kentucky	$ 1,772,224	$ 1,772,224	N/A
Louisiana	N/A	N/A	All LTC/MR
Maine	.5M-NH/2M-Hosp	$ 1,000,000	$100,000 Capital
Maryland	$ 1,450,000	N/A	All
Massachusetts (Acut	$ 9,841,075	$ 524,857	All
Mass. (Non Acute)	$ 1,049,715		
Mass. (LTC Op Budge	$ 558,461		
Michigan	$ 2,352,000	All	All Clinical
Mississippi	$ 2,000,000	$ 1,500,000	All
Missouri	.6M-LTC/1M-Other	.4M-LTC/1M-Other	$ 1,000,000
Montana	$ 1,500,000	N/A	$ 150,000
Nebraska	All LTC	All LTC	All LTC
Nevada	$ 2,000,000	N/A	n/a
New Hampshire	$ 1,759,512	$ 400,000	All
New Jersey	$ 1,000,000	$ 1,000,000	All
New York	$ 3,000,000	$ 3,000,000	All
North Carolina	$ 2,000,000	$ 750,000	certain services
Ohio	$2M Renovations	n/a	n/a
Oklahoma	$ 500,000	N/A	All/w beds
Oregon	All LTC/Hosp	N/A	All LTC/Hosp
Rhode Island	$ 2,000,000	$ 1,000,000	$ 750,000
South Carolina	$ 1,000,000	$ 600,000	$ 400,000
Tennessee	$ 2,000,000	$ 1,000,000	All w/beds
Vermont	$1.5M Hsp/$.75M Other	$ 500,000	$ 300,000
Virginia	$ 5,000,000	N/A	n/a
Washington	$ 1,202,000	N/A	All
West Virginia	$ 2,000,000	$ 2,000,000	23 Services
Wisconsin	$ 1,000,000	$ 600,000	All LTC
Mean	$ 1,500,000	$ 1,000,000	All
Mode	$ 2,000,000	$ 1,000,000	All
Average	$ 1,788,429	$ 1,258,861	$ 150,000

Alaska State Legislature

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Juneau, Alaska 99801-1182
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Chair, Judiciary Committee

Vice-Chair, House Committee on
Economic Development,
Trade and Tourism

Member
Oil & Gas Committee

Representative Lesil McGuire
House District 28

Letter of Intent
CSHB 511 (HES)

It is the intent of the legislature that the Commissioner of the Department of Health and Social Services convene a task force to review existing Certificate of Need procedures and standards. The task force shall identify measures to improve the efficiency and effectiveness of the Certificate of Need Program. The task force shall include members who represent a broad range of health care facilities and providers subject to the Certificate of Need statute. The task force will report its findings and recommendations directly to the Commissioner.

It is further the intent of the legislature that the Commissioner of the Department of Health and Social Services move expeditiously to update Certificate of Need regulations, policies and procedures. In so doing, the Commissioner shall fully consider the recommendations of the Certificate of Need task force.

CSHB 511 (HES) am– CON Bill
Sectional Analysis

Section 1: Amends AS 18.07.031 (c):
Removes the prohibition on using the site from a relocated health care facility for another health care facility without a new certificate of need.

Section 2: Amends AS 18.07.031 (d): Limits the relocation outlined in (c) above to one time.
Amends AS 18.07.031 (e): Includes the net present value of leased space or equipment as part of the cost of a project to calculate the $1 million threshold for CON and closes a loophole in the CON law currently used to avoid the CON process.

Section 3: Amends 18.07.035 clarifies the provision for emergency or temporary certificate of need.

Section 4: Amends AS 18.07.043 regarding standard of review for applications for CON; ADDS Residential Psychiatric Treatment Centers to fall within CON review if the cost is above $1 million.

Section 5: Adds a new section to AS 18.07, relating to the Time Standards for review by department staff for certificate of need reviews, reducing the time from 90 to 60 days.

Section 6: Amends definition in AS 18.07.111 (8) "health care facility" to include independent diagnostic testing facility and residential psychiatric treatment center.

Section 7: Adds a new paragraph to AS 18.07.111 defining (10) "residential psychiatric treatment center".

Section 8: Address applicability issues of the lease and CON filings.

THE
FOLLOWING
DOCUMENT(S)
ARE
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Physical and Electrodiagnostic Medicine

J. Michael James, MD
Larry A. Levine, MD
Michel L. Gevaert, MD
Susan S. Klimow, MD
Shawn P. Johnston, MD
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Sean D. Taylor, MD
Robert F. Valentz, MD
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Carolyn L. Craig, PA-C

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Certified Independent Medical Examiner
Diplomate American Board of Anesthesiology
Certified Subspecialty Pain Medicine ABMS

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851 Westpoint Drive
Suite 303, Wasilla

April 30, 2004

Senate
Health and Social Services Committee

Re: HB511

To Whom It May Concern:

I am writing with regard to HB511, which proposes implementation of "certificate of need" for ambulatory surgery centers, independent diagnostic centers, and independent laboratories.

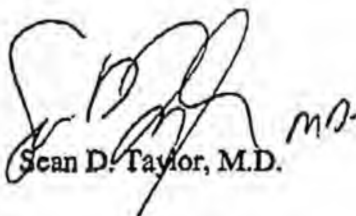
As currently penned HB511 will create a monopoly for the major healthcare corporations, but even more importantly it will limit patient access to affordable high quality care.

I believe by limiting the competition, the cost of the service provided will actually increase. Take for example the telecommunications industry in Alaska. There seem, to be far more examples in business that support competition as a means of lowering the cost for services rendered. I also strongly believe that limiting competition in this manner will lessen the quality of care.

I suggest removing sections 2(d), 2(e), and 4(8) from the proposed legislation from HB511. The bill as written lends itself to the restriction of choice and free market enterprise and fair trade.

In closing, removing the legislation above will help insure quality, affordable care for Alaskans.

Sincerely,



Sean D. Taylor, M.D.

J. Michael James, MD · Michel L. Gevaert, MD · Shawn P. Johnston, MD · Sean D. Taylor, MD · Shawna H. Wilson, ANP-C
Larry A. Levine, MD · Susan S. Klimow, MD · Francine M. Pulver, MD · Robert F. Valentz, MD · Carolyn L. Craig, PA-C

April 30, 2004

Senate
Health and Social Services Committee

Re: HB511

To Whom It May Concern:

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I believe by limiting the competition, the cost of the service provided will actually increase. Take for example the telecommunications industry in Alaska. There seem, to be far more examples in business that support competition as a means of lowering the cost for services rendered. I also strongly believe that limiting competition in this manner will lessen the quality of care as with limited options patients are forced to go to "the only game in town".

It is for these reasons I suggest removing sections 2(d), 2(e), and 4(8) from the proposed legislation.

In closing, removing the legislation above will help insure quality, affordable care for Alaskans.

Sincerely,

Shawn Johnston, M.D.

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Certified Subspecialty Pain Medicine ABMS

TO: Senate Hess Committee members
RE: HB 511 unanswered questions

FROM: Paul Fuhs

Here are some of the critical questions that must be answered to assess the impact of HB511. They were not answered clearly in the house. This is a politically driven bill, sponsored by large medical corporations to limit competition. This is bad public policy for Alaska and will ultimately limit choice and quality for your constituents and increase costs. I hope you will let the parties know that you will expect these answers in hand before a hearing is scheduled on this bill.

Questions for DHSS, bill sponsors and opponents

The hospitals present themselves as community based operations. Please explain their relationships to Bannner Health Corporation ($2.1 billion in annual revenues) in Fairbanks, Triad Hospitals ($3.85 billion in annual revenues) in the Valley, and Providence Health System ($3.5 billion in annual revenues). If they are listed as non-profits, then why do their financial reports state substantial net annual incomes?

The hospitals state that they need to be able to overcharge for imaging to continue operating. Please show the figures that indicate this. Providence has stated that they made $13.4 million in excess revenues over expenses in 2003. What are the figures for Fairbanks and Valley hospitals.

What protections does the Department have in place to prevent overutilization of services from facilities such as hospitals that refer patients to their own diagnostic imaging centers?

What are the differences in methods for determining medicaid reimbursement for technical and professional components of diagnostic imaging services between hospitals and freestanding facilities? Are additional facility charges allowed?

What are the comparative actual fees paid by the medicaid program to hospitals and freestanding facilities for technical and professional components of diagnostic imaging services over the past year?

What are the specific savings that have been identified for Medicaid and for the general public for requiring CON for diagnostic imaging services?

What consideration will quality of services be given in making CON decisions on imaging services?

Independent imaging service providers are paid a flat rate for services provided to Medicaid patients, If this is the case, how will applying CON to independent diagnostic testing facilities provide any savings to state Medicaid costs?

AMENDMENT #1

HB511

Page 4 line 17

Delete: 'independent diagnostic testing facility"

the term excludes

Page 4 line 24

Insert (C) all health care facilities, independent diagnostic testing facilities and the offices of private physicians or dentists whether in individual or group practice for the acquisition, facilities and operation of diagnostic imaging and testing services."

See What Subscribers See

Providence Health System

506 2nd Ave., Ste. 1200
Seattle, WA 98104-2329 (Map)
http://www.providence.org

Phone: 206-464-3355
Fax: 206-464-3038

Covered by Angela Boeckman

Sisterhood is powerful in health care. The order of the Sisters of Providence runs not-for-profit Providence Health System in the Pacific Northwest (with outposts in Alaska and southern California). The system operates about 20 acute care hospitals, some of which offer specialized care centers for cancer and heart disease. Other services include long-term care and assisted-living facilities and primary care centers. In addition Providence Health System offers health plans, low-income housing, and home health, hospice, and various community outreach services.

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Key Numbers

Company Type	Private - Not-for-Profit
Fiscal Year-End	December
2002 Sales (mil.)	$3,528.6
1-Year Sales Growth	7.8%
2002 Net Income (mil.)	$58.0
1-Year Net Income Growth	(38.8%)
2002 Employees	33,920
1-Year Employee Growth	3.0%

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Key People

Chairman	Kay Stepp
President and CEO	Henry G. (Hank) Walker
Acting President and CEO, EVP, and COO	John F. Koster
VP and CFO	Subscribers Only
VP, Strategic Development	Subscribers Only

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Industry Information

- Health Care

  Health Care Services

  - **Hospitals (primary)**
  - Home Health Care
  - Long-Term Care Facilities
  - Specialized Health Care Services

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International Search
Pro Tools
Find Similar Companies
Add E-Mail News Alerts
Build Company List (Advanced Search)
Build Executive List (Advanced People Search)
Custom News Search
Target IPO Companies
StockScreener
Tools
Profile View

Triad Hospitals, Inc. (NYSE: TRI)

5800 Tennyson Pkwy.
Plano, TX 75024 (Map)
Phone: 214-473-7000
Fax: 214-473-9411
Toll Free: 800-238-6006

http://www.triadhospitals.com

Basic Financial Information

Company Type	Public (NYSE: TRI)
Fiscal Year-End	December
Financial Filings	SEC
Auditor	Subscribers Only
Annual Report	Company Web Site
Investor Relations	Company Web Site

Financial Overview

Last Close 28-Apr-2004	$33.81
52-Week High	$38.00
52-Week Low	$21.50
Basic EPS	$1.93
Price/Earnings Ratio	17.52
Current Ratio	1.83
R&D Expense	Subscribers Only
Advertising Expense	Subscribers Only
% Owned by Institutions	91.6%

	2003	2002	2001	2000
Annual Sales ($ mil.)	3,865.9	3,541.1	2,669.5	1,235.5
Annual Net Income ($ mil.)	95.2	141.5	2.8	4.4

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1441 N. 12th St.
Phoenix, AZ 85006 (Map)
http://www.bannerhealth.com

Phone: 602-495-4000
Fax: 602-495-4559

Basic Financial Information

Company Type	Private - Not-for-Profit
Fiscal Year-End	December

Financial Overview

	2002	2001	2000	1999
Annual Sales ($ mil.)	2,100.0	1,900.0	1,734.6	1,560.6

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- U.S. Attention Deficit Hyperactivity Disorder (ADHD) Markets
  (Frost & Sullivan, May 30, 2003, Business Reports)
- The Cancer Outlook to 2007
  (Reuters Business Insight, Jun 1, 2002, Business Reports)
- Plunkett's Health Care Industry Almanac 2003
  (Plunkett Research, Ltd., Sep 23, 2002, Books)
- Benign Prostatic Hyperplasia: Expanding the drug treated population
  (Datamonitor, Jun 4, 2003, Business Reports)
- ValuEngine Quantitative Industry Report for HOME HEALTH CARE
  (ValuEngine, Inc., Nov 1, 2002, Business Reports)
- World Health Care I to 2004- Developed Countries (Study # 1384)
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Sam Korsmo testimony Senate HESS April 5, 2004 HB511

I am a private investor. Our company is composed entirely of Alaskans and we are providing superior service to our patients at up to 30% less price than the hospitals.

The bill's sponsor says it is just to level the playing field but this is not the case. We offered an amendment in the house that would have eliminated CON for all providers of imaging services including hospitals even though Providence Hospital already avoided CON by setting up a wholely owned subsidiary, Providence Imaging Center.

This amendment, which I hope you will consider applying to HB511, would level the playing field by removing CON requirements from all health care providers, including hospitals. The first document in the information I gave you shows the other states who have CON programs but have excluded imaging equipment. This is in recognition of the fact that imaging is a technology driven sector that you want to constantly upgrade. It is also in recognition that diagnostic imaging saves money for the overall medical system due to reducing unnecessary surgeries and early detection.

When the big hospitals were offered this amendment to level the playing field they rejected it proving the HB511 is a clear restriction of competition. But it is not competition with the small community facilities. The Department of HSS wrote to the House Finance committee that "New imaging will not develop in small communities where there are low patient volumes."

The hospitals claim they need this legislation because they have mandates to cover low pay and no pay patients. This is a false claim since the independent facilities also do the same thing. The second page in our handout shows that in 2003 22.04 % of our

patients were medicaid/medicare and that we assumed uncompensated debts of $1,222,373.

The big hospitals have provided no data to justify their claims. Although they are claiming poverty, Providence made $13.4 in profits in 2003. The information you were provided during your last show that these hospitals are run by huge corporations with billions of dollars in annual revenues.

The Department has also provided no data on any savings from applying CON to imaging.

Regards to Medicaid, you may not be aware that there is a differential payment method for hospitals. Hospitals can charge Medicaid a percentage of their overall facility costs whereas the independent facilities are paid a flat rate. Couple these higher prices with the ability of the hospitals to self refer patients to their own facilities. This should be thoroughly investigated. We asked the department to run these numbers and they told us that they do not have them

By comparison our facilities have saved Medicaid money because with our superior technology we can handle claustrophobic and overweight patients that used to have to be flown outside. Medicaid affirmed that we saved this program $1.6 million over the past two years.

The Department cites the Michigan study done by Ford Motors as claiming savings from CON there, but when we called Stan Nash, the CON director for Michigan, he said they didn't use that study at all since they wouldn't release the raw data and the study had not been peer reviewed. They pointed us instead to the Duke study which drew far different conclusions.

Please support the amendment excluding all imaging providers from CON requirments, or change the levels of expenditure to reflect the changes in inflation and costs since the level was set in the 1980's. The leasing provisions for buildings should also be removed from the bill since it is not construction. If these changes are not made, please do not move this bill from committee until all regulations are done or a thorough study has been completed to determine if CON works for Alaska.

Paul Fuhs

PROFESSIONAL SERVICES

E-Mail: paulfuhs@earthlink.net

1635 Sitka #301 Anchorage, Alaska 99501 Phone: (907) 351-0407 Fax: (907) 272-2754

Senator Dyson

Here is the information on states without CON and those that have excluded imaging from CON requirements.

The federal government initiated CON but recognized it as a failed method to control costs and has done away with it entirely

The following 14 states have no CON program:

California
Arizona'
New Mexico
Texas
Colorado
Utah
Idaho
Wyoming
North Dakota
South Dakota
Minnesota
Indiana
Pennsylvania
Kansas

In addition, the following states that have a CON program do not apply it to diagnostic testing:

Nebraska
Nevada
Florida
Oregon
Iowa
Washington
Lousiana
New Jersey
Deleware
Ohio
Wisconsin
Arkansas
Oklahoma

That is 27 states, by far the majority.

ALASKA OPEN IMAGING CENTER

From: Sam Korsmo
Re: Medicaid/medicare no pay/low pay patients

April 5, 2004

Alaska Open Imaging Center accepts all patients that come to our facility. For the year 2003, Medicaid/medicare patients were 22.04 % of our total business activity. In addition we incurred and paid uncompensated debts of $1,222,373 for 2003.

We have not heard any data from the hospitals but we would be interested to see it.

Tanana Valley Clinic provided $1,183,812 in uncompensated care to indigent patients in 2003, or 4.6% of our net patient revenues. Fairbanks Memorial Hospital reports that they provided $1,872,168 in uncompensated care in 2003, or 1.8% of their net patient revenues. Fairbanks Memorial Hospital projects that they will decrease uncompensated care as a percent of net patient revenues in the 7 year period from 2000 – 2006.

In addition to the uncompensated care provided to indigent patients, TVC incurred another $5,619,380 or 21.9% of net patient revenues in contractual adjustment taken due to the fact that we accept thousands of Medicare and Medicaid patients each year. We are the only private clinic in the Interior that accepts any patients, with Medicare, Medicaid or without insurance. We have been doing that for 45 years, and intend to continue with that long tradition of service to the community.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER
FINANCE AND MANAGEMENT SERVICES

FRANK H. MURKOWSKI, GOVERNOR

P.O. Box 110650
Juneau, AK 99811-0650
Phone: (907) 465-3082
Fax: (907) 465-2499

May 3, 2004

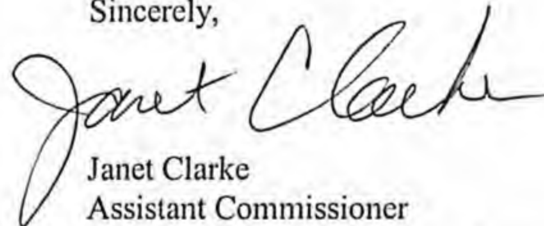
Senator Fred Dyson, Chair,
Senate HESS Committee
State Capital, Room 205
Juneau, AK 99801-1182

Dear Senator Dyson

Attached is a packet of Certificate of Need Information that has been prepared for the HESS Committee meeting on May 3, 2004. Included in the packet are the following documents;

- Page 1 - General Certificate of Need Questions and Answers about what would change if HB 511 is passed;
- Page 2 - The Impact of HB 511 Changes on Ambulatory Surgery Centers;
- Page 3 - The Function of Licensing;
- Page 4 - When Are Certificate of Need Documents Made Public;
- Page 5 - The CON Timeline – Best Case Scenario;
- Page 6 - A Description of a Certificate of Need Review;
- Page 7 - Applicability of HB 511 to Current Projects;
- Page 8 - Certificate of Need Thresholds by State – 2001.

Sincerely,



Janet Clarke
Assistant Commissioner
Department of Health and Social Services

CC: Senator Lyda Green
Senator Gary Wilken
Senator Bettye Davis
Senator Gretchen Guess

CERTIFICATE OF NEED QUESTIONS & ANSWERS

Question: What types of projects are required to submit a certificate of need application and go through the review process?

Answer: Any health care facility project that involves the expenditure of $1 million or more for construction, renovation or the purchase of new equipment, and any project, regardless of cost, that converts space into nursing home beds is required to submit a certificate of need application.

Question: Are there any types of "health care facility" projects that are currently exempt from the certificate of need program?

Answer: Projects are exempt from certificate of need if: 1) the project cost is under the $1 million threshold; 2) the project is for routine maintenance or routine replacement regardless of the cost; 3) the project is for specifically exempted Pioneer Homes, private physicians' offices, or dentists' offices; or 4) the project is not included in the definition of "health care facility."

Question: Will the definition of a "health care facility" change if HB 511 passes?

Answer: Yes. If HB 511 passes, two additional types of facilities will be added to the list of those projects that may be required to go through the CON process: 1) Residential Psychiatric Treatment Centers (RPTCs), and 2) independent diagnostic testing facilities.

Question: Are all projects exempt from certificate of need if they fall below the $1 million dollar threshold? Will there be any changes to items counted in the threshold?

Answer: All projects that cost less than $1 million are exempt from certificate of need except for space converted to nursing home beds, which must submit a CON application regardless of cost. HB 511 requires the net present value of leased space and equipment to be counted in the threshold.

Question: What are the components of the certificate of need (CON) process?

- Submission of a letter of intent - (includes who, what, where, how large, the cost and timeline);
- Letter of intent (LOI) determination - a decision is made as to whether a CON is required;
- Application - An application may be submitted 60 days after the LOI determination;
- Completeness Check - The application is checked for completeness. More information is requested if it is found incomplete. The applicant has 60-days to submit additional information;
- Review Period - The analysis document must be submitted to the Commissioner in 90 days;
- Public Notice & Public Comment – Public notice is given at the beginning of a review and the public comment period runs for 30 days concurrently with the review,
- Decision - The Commissioner makes the decision, which is published; and
- Appeal - The applicant has 30 days to appeal if dissatisfied.

Question: If I apply for a certificate of need, how long will it take for a decision?

Answer: Once your application is received and declared complete, a review document must be submitted to the Commissioner for a decision within a maximum of 90 days. The Commissioner does not have a timeline to make a decision, but generally makes one in a couple of weeks.

Question: How much does it cost to prepare a certificate of need application?

Answer: That depends on the size of the project, its complexity and whether it is controversial. A rule of thumb is that a certificate of need application should not cost more than 1% of the total project cost with a maximum of $25,000. Health Facilities Planning and Development, a consulting firm that writes approximately 70% of all CON applications for facilities in Washington State and has done at least 4 applications in Alaska, charges approximately $15,000 per application, regardless of the size of the facility. Appeals would, of course, lead to additional costs.

The Impact of the Changes in HB 511 on Ambulatory Surgery Centers:

The current certificate of need law allows an existing ambulatory surgery center (ASC) to move to a new location without going through the certificate of need process, as long as it is not considered an expansion of services, which means it would not build additional surgery suites and the vacated facility will not continue to be used as an ambulatory surgery center.

HB 511 allows an ambulatory surgery center to move once without a certificate of need and allows the vacated facility to continue to be used as an ASC, but not by the same owner/operator. The reason that it cannot be owned/operated by the same entity is due to the key word "relocate" in the new law. An ASC cannot relocate and stay in the same place. However, this does not prohibit the vacated building from being sold or leased to a new owner and operated as an ASC.

The Function of Licensing

Licensing does not limit the capacity of services in any way, it only ensures that once they are built and in operation that certain quality measures are maintained. Following is a description of community care licensing and what it does.

Community Care Licensing

Statutory purpose of community care licensing as stated in AS 47.35.005

- To establish and maintain standard levels for services offered to children
- To reduce predictable risk of harm to children and to provide support services to those providing child care or services

AS 47.35.015 requires the licensure of all RPTCs

Specific requirements must be met in order to be licensed. The most critical are:

- Criminal background check of the Program Administrator and all prospective employees
- Appropriate policies and procedures need to be in place that relate to both personnel and program practices
- Facility requirements such as compliance with regulations regarding:
    - Fire safety codes
    - Environmental health and safety standards
    - Space requirements – e.g. sizes of bedrooms, storage and work space areas, bathrooms, outdoor recreation space
    - Equipment and Supplies – e.g. clean beds, towels; phones, developmentally appropriate toys

Licensing applications are made by programs/facilities that are operating or ready for operation

Licensing staff CAN work with program/entities that are in the process of building a program, to advise them of the regulations that must be followed.

Licensing does not determine the need for the facility – it determines the quality and standards of the program as per Alaska Statute

Timelines for licensing:

> **Review of completeness of an application - 10 days**
> **Inspection and investigation of an application – 90 days following receipt of application**

WHEN ARE CERTIFICATE OF NEED DOCUMENTS MADE PUBLIC?

- When a letter of intent is received the information is placed on the certificate of need web site.
- When a certificate of need application is determined to be complete, notice of the review is published and interested parties contacted.

The CON Review Timeline – Best Case Scenario

- **Day 1 - Letter of Intent Recieved** – The certificate of need process begins with a letter of intent that includes a project description (who, what, where & capacity); 2) the estimated project cost; and 3) the estimated starting and completion date of the construction/equipment installation. I
- **Day 2 – A determination is made** – A determination can usually be made in a day or two. If a certificate of need is not required, this is the end of the process. If a certificate of need is required, the 60-day wait begins. If the application is a modification of an existing approved CON, the 60-day wait is not required.
- **Day 62 – The Application is submitted** – The applicant is notified that the application was received and the completeness check is started.
- **Day 65 – The Completeness Check is Finished** – A completeness check can usually be finished in 2-3 days depending on the staff work load and the complexity of the application. If an application is declared complete, the review period starts immediately.
- **Day 66 – The Review begins** – The applicant, and public are notified, the public comment period starts, a site visit is often done. National and regional data is reviewed and the applicant statement of need is analyzed. Findings and recommendations are developed and placed in the review document. The least amount of time this could take is 45-days.
- **Day 111 – Submission to the Commissioner** – Although the Commissioner has no time period to make the decision, it usually takes a week or two.
- **Day 118 – Submission to the Commissioner** – Although the Commissioner has no time period to make the decision, it usually takes a week or two. If the project is approved as requested then this would be the end of the review process.

One activity of the program is to provide certificate of need education to anyone who is considering submission of a certificate of need application. One of the main objectives is to encourage potential applicants to submit early and not to wait to the last minute before they want to build. That way the process does not interfere with the movement of the project from planning to completion.

A Description of a Certificate of Need Review

Jean Stevens, Administrator of the Renal Care Group Alaska (RCGA) kidney dialysis center, contacted the Department in 2001 about plans for expansion. They were interested in several locations including Fairbanks, Wasilla, Juneau, and Anchorage. She requested technical assistance, which was provided on July 10, 2001, when staff met with Jean and some of her staff and provided an educational session on the CON process and answered questions about the application packet. An application packet is given to RCGA.

3/25/2003 – A letter of intent was received from Renal Care Group for a 12-station dialysis center to be located in Wasilla costing $1.3 million. The proposed construction was planned to start in June 2003 and be completed by September 2003.

3/26/03 – The Department notifies RCGA that this project requires a certificate of need and that an application can be submitted at any time between May 26, 2003 and March 26, 2004.

6/4/2003 – RCGA submits a CON application for the project in Wasilla.

6/6/2003 – The RCGA application is declared complete and notification is sent to RCGA, the Commissioner's office, health care facilities in Wasilla, appropriate state officials, and notice is sent to the newspaper for publication. The applicant is notified that the review document will be submitted to the Commissioner by September 4, 2003.

6/15/2003 – Public Notice of the review is published for two consecutive days in the Anchorage Daily News. Announcement includes information on the project, the review period, where to submit public comment and the end of the comment period (until July 15), the fact that a public meeting could be requested, and location of the application if anyone wanted to read it.

7/31/2003 – The review is completed and the review document submitted to the Commissioner's office. The review recommends approval.

9/24/2003 – The Commissioner approves the project as requested.

9/24/2003 – The applicant is notified and several days later notification is published in the newspaper. The time to appeal begins and ends 30 days later.

Applicability of HB 511 to Current Projects

After consultation with the Attorney General's Office, here is the interpretation of the applicability of HB 511 to current projects:

Any project (including Residential Psychiatric Treatment Centers - RPTC's) that has begun construction at the time that HB 511 becomes law will be given a waiver and will not be required to go through the CON process if the following conditions are met:

1) Construction must have been started (construction does not include landscaping or preliminary architectural drawings, but does include foundational work, plumbing, and slabs for the floor);
2) A full set of architectural drawings must be complete;
3) A building permit must be in hand along with any necessary code approvals; and
4) Projects must be complete within two years.

Certificate of Need Thresholds By State - 2001

State	Capital	Equipment	New Service
Alabama	$ 3,200,000	$ 1,500,000	All
Alaska	$ 1,000,000	$ 1,000,000	$ 1,000,000
Arkansas (LTC)	$ 500,000	N/A	All Home Health
Connecticut	$ 1,000,000	$ 400,000	All
Delaware	$ 5,000,000	$ 5,000,000	N/A
Dist. of Columbia	$ 2,000,000	$ 1,300,000	$ 600,000
Florida	None	None	All
Georgia	$ 1,155,881	$ 642,157	All
Hawaii	$ 4,000,000	$ 1,000,000	All
Illinois	$ 6,000,000	$ 6,000,000	All new, expansions
Iowa	$ 1,500,000	$ 1,500,000	$ 500,000
Kentucky	$ 1,772,224	$ 1,772,224	N/A
Louisiana	N/A	N/A	All LTC/MR
Maine	.5M-NH/2M-Hosp	$ 1,000,000	$100,000 Capital
Maryland	$ 1,450,000	N/A	All
Massachusetts (Acut	$ 9,841,075	$ 524,857	All
Mass. (Non Acute)	$ 1,049,715		
Mass. (LTC Op Budge	$ 558,461		
Michigan	$ 2,352,000	All	All Clinical
Mississippi	$ 2,000,000	$ 1,500,000	All
Missouri	.6M-LTC/1M-Other	.4M-LTC/1M-Other	$ 1,000,000
Montana	$ 1,500,000	N/A	$ 150,000
Nebraska	All LTC	All LTC	All LTC
Nevada	$ 2,000,000	N/A	n/a
New Hampshire	$ 1,759,512	$ 400,000	All
New Jersey	$ 1,000,000	$ 1,000,000	All
New York	$ 3,000,000	$ 3,000,000	All
North Carolina	$ 2,000,000	$ 750,000	certain services
Ohio	$2M Renovations	n/a	n/a
Oklahoma	$ 500,000	N/A	All/w beds
Oregon	All LTC/Hosp	N/A	All LTC/Hosp
Rhode Island	$ 2,000,000	$ 1,000,000	$ 750,000
South Carolina	$ 1,000,000	$ 600,000	$ 400,000
Tennessee	$ 2,000,000	$ 1,000,000	All w/beds
Vermont	$1.5M Hsp/$.75M Other	$ 500,000	$ 300,000
Virginia	$ 5,000,000	N/A	n/a
Washington	$ 1,202,000	N/A	All
West Virginia	$ 2,000,000	$ 2,000,000	23 Services
Wisconsin	$ 1,000,000	$ 600,000	All LTC
Mean	$ 1,500,000	$ 1,000,000	All
Mode	$ 2,000,000	$ 1,000,000	All
Average	$ 1,788,429	$ 1,258,861	$ 150,000

CURRICULUM VITAE

Date prepared: May 3, 2004

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Date of birth: 4/22/51 **Place:** Salzburg, Austria **Citizen of:** U.S.A.

Education:	**Place:**	**Date:**	**Degree:**
College:	Franklin & Marshall Lancaster, PA	1972	B.A. (Government)
Graduate or Professional School:	University of Minnesota Minneapolis, MN	1981	M.A. (Political Science)
	RAND Graduate School Santa Monica, CA	1979 1995	M.Phil. (Policy Analysis) Ph.D. (Policy Analysis)*

*Dissertation Title: *Potential Mortality Reduction Under Universal Health Coverage*
Dissertation Committee: Albert P. Williams, chairman (deceased); Patricia M. Danzon; Grace M. Carter

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PROFESSIONAL TRAINING AND ACADEMIC CAREER

11/72 - 9/73: *Research Analyst*, **House Republican Conference**, Washington, DC

9/73 - 6/74: *Teaching Assistant*, Department of Political Science, **University of Minnesota**, Minneapolis, MN

6/74-8/74: *Research Analyst*, **Center for New Democratic Processes**, Minneapolis, MN

8/75-6/76: *Research Analyst*, **Governor's Commission on Crime Prevention and Control**, St. Paul, MN

9/74-8/78: *Research Analyst*, **RAND Corporation**, Santa Monica, CA

9/81-9/83: *Instructor*, Department of Political Science, **University of Kentucky**, Lexington, KY

1/79-2/82: *Policy and Budget Analyst IV*, **State of Kentucky, Cabinet for Human Resources**, Frankfort, KY

2/82-2/84: *Director*, Center for Health Policy Development, **State of Kentucky, Cabinet for Human Resources**, Frankfort, KY

4/82-2/84: *Executive Director*, **Governor's Coalition of Payors to Address Health Care Costs**, Frankfort, KY

2/84-8/84: *Consultant*, **Lexington Clinic**, Lexington, KY

6/84-6/96: *Associate in Research*, Center for Health Policy Research and Education, **Duke University**, Durham, NC

8/90-6/92: *Adjunct Assistant Professor*, Public Policy Studies, Institute of Public Policy, **Duke University**, Durham, NC

7/96-6/97: *Assistant Research Professor*, Center for Health Policy Research and Education (now Center for Health Policy, Law and Management), **Duke University**, Durham, NC

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11/03-Present: *Senior Research Fellow*, Health Inequalities Program, Center for Health Policy, Law and Management and Terry Sanford Institute of Public Policy, **Duke University**, Durham, NC

PUBLICATIONS

Journal Articles:

1. Hall, MA and **Conover CJ**: "The Impact of Blue Cross Conversions on Accessibility, Affordability, and the Public Interest." *Milbank Quarterly* 81, No. 4 (2003): 509-542. http://www.milbank.org/quarterly/8104feat.html
2. Sloan FA, Ostermann J, **Conover CJ**: "Antecedents of Hospital Ownership Conversions, Mergers, and Closures." *Inquiry* 40, No. 1 (Spring 2003): 39-56.
3. Sloan FA, **Conover CJ**, Ostermann J. "Rates of Return from Hospital Conversions," *Health Care Management Review* 28, No. 2 (April-June 2003): 107-17,.
4. **Conover CJ,** Whetten-Goldstein K. "The Impact of Ancillary Services on Primary Care Use and Outcomes for HIV/AIDS Patients with Public Insurance Coverage." *AIDS Care* 14, Supplement 1 (August 2002): S59-S71.
5. Sloan FA , **Conover CJ**, Mah ML, Rankin PJ. "Impact of Medicaid Managed Care on Utilization of Obstetric Care: Evidence from TennCare's Early Years" *Southern Medical Journal* 95, No. 8 (August 2002): 811-821.
6. **Conover CJ,** Rankin PJ, Sloan FA,. "Effects of Tennessee Medicaid Managed Care on Obstetrical Care and Birth Outcomes." *Journal of Health Politics, Policy and Law* 26, No. 6 (December 2001): 1291-1324.
7. Sloan FA, Rankin PJ, Whellan DJ, **Conover, CJ.** AMedicaid, Managed Care and the Care of Patients Hospitalized for Acute Myocardial Infarction.@ *American Heart Journal* 139, No. 4 (April 2000): 567-76.
8. Sloan FA, **Conover CJ,** Provenzale, D: AHospital Credentialing and Quality of Care." *Social Science and Medicine* 50, No. 1 (January 2000): 77-88.
9. **Conover CJ.**, Mah M, Rankin PJ, Sloan FA. "Physician Participation and Nonparticipation in Medicaid Managed Care: The TennCare Experience." *Southern Medical Journal* 92, No. 11 (November 1999): 1064-70.
10. Sloan FA, **Conover, CJ**, Hall MA. "State Strategies to Reduce the Growing Numbers of People without Health Insurance." *Regulation* 22, No. 3 (Fall 1999): 24-31.
11. **Conover CJ,** Mah ML, Rankin PJ, Sloan FA. "The Impact of TennCare on Patient Satisfaction with Care." *American Journal of Managed Care* 5, No. 6 (June 1999): 765-775.
12. **Conover CJ**, Sloan FA., Provenzale, D, Oddone E, Jowell PS, Mah ML: "Hospital Credentialing for Laparoscopic Cholecystectomy: Is Stricter Better?" *Clinical Performance and Quality Health Care* 6, No. 4 (October/November/December 1998): 155-162.
13. Sloan FA, **Conover CJ**: "Effects of State Reforms on Health Insurance Coverage of Adults" *Inquiry* 35, No. 3 (Fall 1998): 280-293.
14. **Conover CJ**, Sloan FA: "Does Removing Certificate of Need Lead to a Surge in Health Care Spending?"*Journal of Health Politics, Policy and Law* 23, No. 3 (June 1998): 455-481.
15. Sloan FA, **Conover CJ**: "Life Transitions and Health Insurance Coverage of the Near Elderly." *Medical Care* 36, No. 2 (February 1998): 110-125.
16. Sloan FA, Viscusi WK, Chesson HW, **Conover CJ**, Whetten-Goldstein K: "Alternative Approaches to Valuing Intangible Health Losses: The Evidence for Multiple Sclerosis." *Journal of Health Economics* 17, No. 4 (1998): 475-497.

Prior to Duke Faculty Appointment

17. Whetten-Goldstein K, Sloan F, **Conover CJ**, Viscusi K, Kulas B, Chesson H. "The Economic Burden of Multiple Sclerosis." *MS Management*. 3, No. 1 (1996):33-39.
18. **Conover CJ,** Sloan FA: "Bankruptcy Risk and State Regulation of Continuing Care Retirement Communities." *Inquiry* 32, No. 4 (Winter 1995/96): 444-456.
19. Sloan FA, Shayne MW, **Conover CJ**: "Continuing Care Retirement Communities: Prospects for Reducing Institutional Long-Term Care." *Journal of Health Politics, Policy and Law* 20, No. 1 (Spring 1995): 75-98.

20. Weinberger M, **Conover CJ**, Samsa GP, Greenberg S: "Physicians' Attitudes and Practices Regarding the Treatment of HIV-infected Patients." *Southern Medical Journal* 85, No. 7 (July, 1992): 683-686.
21. **Conover CJ**, McLaughlin M: "Spreading the Risk and Beating the Spread: The Role of Insurance in Assuring Adequate Health Care." *North Carolina Insight* (Winter, 1991).
22. **Conover CJ**: "Indigent Medical Care in Kentucky." *Kentucky Economy Review and Perspective* (September, 1982).
23. Stumbo WG, Allen DT, **Conover CJ**: "Understanding Medicaid in Kentucky." *Journal of the Kentucky Medical Association* 79, No. 3 (March, 1981): 156-167.
24. Gray, CM, Conover CJ, Hennessey TM. "Cost-effectiveness of Residential Community Corrections—Analytical Prototype." *Evaluation Quarterly* 2, No 3 (1978): 375-400.

Papers Under Review/Manuscripts in Revision:
1. **Conover CJ**, Ettner SL, Weaver M, Flynn PM, Porto JV. "Economic Evaluations of HIV Treatment and Health Research with People Diagnosed with HIV Infection and Co-Occurring Mental Health and Substance Abuse Disorders." Submitted to *AIDS Care* September 2003.
2. Lobach DF, Arbanas J, Campbell M, Wildemuth B, Yarnell KH, Hasselblad V, **Conover CJ**. "Enhanced Patient Data Collection from Individuals with Low Reading Literacy Using an Adaptive Human-Computer Interface during the Computer-Assisted Patient Interview: A Randomized Controlled Trial." Submitted August 2003.
3. Sloan FA and Conover CJ. "Certificate of Need for Acute Care Services: Should States End It or Mend It?" Under revision.

Papers in Preparation:
1. **Conover CJ**, Lobach DF, Arbanas J. "Cost-effectiveness of Using a Web-based Patient History to Address Health Literacy" for submission to *Health Care Financing Review*.
2. **Conover CJ**, Ang A, Arno P, Ettner SL, Flynn PM, Weaver M, Porto JV. "Costs of Care for People Living with Combined HIV/AIDS, Chronic Mental Illness, and Substance Abuse Disorders" for submission to *New England Journal of Medicine.*
3. **Conover CJ**, Hall MA, Osterman J. "The Impact of Blue Cross and Blue Shield Conversions on Health Expenditures and the Uninsured" for submission to *Health Affairs*.
4. **Conover CJ**, Ang A, Arno P, Ettner SL, Helminiak T, Weaver M, Porto JV. "What are the Social Costs of People Living with Combined HIV/AIDS, Chronic Mental Illness, and Substance Abuse Disorders?" for submission to *Journal of Policy Analysis and Management.*
5. Ettner SL, Ang A, Arno P, **Conover CJ**, Weaver M. "Use of Long-Term Care Services Among Triply Diagnosed HIV Patients" for submission to *Medical Care*.
6. Weaver M, Ang A, Arno P, **Conover CJ**, Ettner SL. "Access to Health Care for People Living with Combined HIV/AIDS, Chronic Mental Illness, and Substance Abuse Disorders" for submission to *Health Services Research*.
7. Arno P, Sohler N, **Conover CJ**, Ettner SL, Theilman N. "Medication Use Patterns and Costs in Patients with HIV, Mental Illness, and Substance Abuse Disorders" for submission to journal TBN.

Monographs:
1. **Conover CJ.** *A Review and Synthesis of the Cost and Benefits of Health Services Regulations* Durham: Duke University, Center for Health Policy, Law and Management, July 2003
2. **Conover CJ.** Sloan FA, *Evaluation of Certificate of Need in Michigan. Volume II: Technical Appendices*. Durham: Duke University, Center for Health Policy, Law and Management, July 2003. http://www.michigan.gov/mdch/0,1607,7-132-2945_5106_5409-83771--,00.html
3. **Conover CJ,** Hall MA. *For-Profit Conversion of Blue Cross and Blue Shield of North Carolina: Assessment of the Potential Impacts on Accessibility and Affordability of Health Care.* A

Testimony of Jeff Kinlon, CEO Alaska Open Imaging Center, May 3, 2004

I have been involved in the delivery of medical care for almost 30 years, 26 of those years in hospital employment before going independent in 2000. I have seen the status-quo approach of hospitals not caring or wanting to advance technology and/or care because they did not have to..... until competition came into the equation. One local example of this is Valley Hospital, they did not, would not install a DEXA bone density unit to evaluate osteoporosis through several years of budgetary request. A competitor installed one in the area and **then** the hospital made a move to provide this service within months. Another case in point with one of the most

expensive technologies is PET scanning and Providence Hospital. Providence talked and planned, promised and recanted for years without bringing the needed technology to Alaska. A competitor to the hospital then brought PET to Alaska, offered a cost effective, cooperative arrangement to Providence Hospital only to have Providence Hospital negatively react and commit to a 2.8 million dollar machine to duplicate the service, which by the way was NOT CON approved. Their un-level playing field they are so vocal about does not exist. Competition in medicine already has benefited the people of Alaska, competition has pushed the level of technology and care up and competition will work towards pushing the costs down.

A serious strain is impending on the medical delivery in Alaska and the Department of Health and Social Services in cooperation with the multi-billion dollar, out-of-state hospitals are organizing for a double standard, monopolistic power grab that will ultimately cost the citizens of Alaska hundreds of millions of dollars.

They are now attempting to steam roll this legislation through YOU without YOU having all the facts or enough time for you to analyze these facts and make a sound decision.

The State of Alaska and all of the Alaska citizens need your clear thinking and wisdom now.

Medical economics certainly are different than other industries, but that doesn't mean that specific fundamentals such as competition do not exist or have value. Hospitals compete with other hospitals, for doctors, for patients, for staff. Physician offices compete with other physician offices. Services compete with other services. The benefit of competition is an advantage to the end user, the patients and their doctors. **Competition drives the level and delivery of healthcare up while driving the cost of healthcare down.** Competition works where the CON was designed to but never did.

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Something, several things need to be done to improve the condition of healthcare in Alaska, but not the wrong thing. House Bill 511 is wrong. It is wrong in the reasoning it has used, it is wrong in the way it has been manipulated, it is wrong for the people of Alaska and it is wrong to think competition has no place at all in the delivery of healthcare. Amend, modify or defeat House Bill 511, but do not let it pass this committee in its present form and negatively impact the citizens of Alaska without truly knowing what that impact will be.

Thank you for your consideration of these points and I will answer any question I can.

Testimony to Senate regarding HB511 of behalf of Val D. Christensen, M.D.

1. Name and Background: I am a nine-year Alaskan resident and am board certified in diagnostic radiology. I am presently working as a radiologist for Alaska Open Imaging Center. I have previously worked as the Chairman of the Department of Radiology and Nuclear Medicine at Elmendorf USAF Hospital for 5 years supervising up to six radiologists and 30 technicians. I moved back to Alaska with family of 8 children and a very big commitment and belief in the future of Alaska including a free and open market for business competition and free enterprise. In fact, the opportunity to make a significant positive impact on the improvement of healthcare and choices and opportunities for patients in Alaska was a chief draw.

2. HB511 represents collusion with intent of restraint of trade and is the antithesis of American free enterprise and our Alaskan motto of "North to the Future." It represents a giant leap backwards to the era of "might makes right."

3. HB511 guarantees monopolistic control of the medical imaging market with a two-tiered price-fixing system and gouging of the Alaskan public. This is the business equivalent of telling John Doe that he can't open and equip an auto repair shop because we already have a Ford and Chevy dealer in town.

4. Representative Samuel's plea for fairness on the front end sounds good but in reality absolutely destroys fairness on the back end. What he didn't say is that from here on out, a small independent facility would have <u>no chance</u> to acquire new equipment or replace old equipment in a world dominated by hospital deep-pockets and political connections.

5. The representative from Fairbanks, who admitted to sitting on a hospital board, stated that there is a 30% increase in the chance of errors in clinics versus hospitals. This is impossible and somewhat unbelievable without citation of a mainstream, peer reviewed study. There are several big studies, including publication in JAMA (Journal of the American Medical Association), documenting a totally unacceptable rate of fatal errors in hospitals, which has filtered down to recent popular press (Reader's Digest).

6. He also stated that 33 states have a Certificate of Need program. What he didn't say is that 49 of the 50 states had a CON program originally and that federal administrators dropped the CON program in the 80s and the rest of the states did the same as the program didn't work.

7. He also stated that medical economics work differently. That is true, but he didn't state why. The reason is because of self-referral, i.e. when a doctor sees a patient and then refers the patient to their own imaging center. This is worse if the hospital owns the equipment. Alaska Open Imaging Center cannot do this as our radiologists don't have initial visits with the patients.

8. Independent outpatient centers do imaging more efficiently, more economically, and with a higher standard of care. They are not subject to the costs of CON (which can be up to $100,000) or bureaucratic costs, all of which are passed along to patients. Independent outpatient centers are not involved in over utilization and inflated costs of self-referral.

9. Hospitals should stick to what they do best which is inpatient care of ill people who need imaging. They should NOT attempt a monopoly on all business, especially outpatient imaging for the purpose of "cost-shifting." This was NEVER in the mandate to begin with.

10. HB511 is being ramrodded through as quickly as possible because the powers behind it don't want you to have the time to read the studies and learn the true facts. It threatens my livelihood personally. Alaskan patients, and payers on their behalf, also stand to loose big time.

Val D. Christensen, M.D. — Date
Radiologist for Alaska Open Imaging Center

South Peninsula Hospital

April 30, 2004

Senator Fred Dyson, Chairman
Health, Education and Social Services Committee
State Capitol, Room 125
Juneau, Alaska 99801-1182

Dear Senator Dyson

I am the Chief Executive Officer of South Peninsula Hospital, a small community owned and operated hospital in Homer. Our hospital has served the community since 1956. I have served as its CEO since 1995. This year I also have the honor of serving as the Chairman of the Board of Directors of the Alaska State Hospital and Nursing Home Association. I would like to share my perspective on HB 511.

You have heard testimony from representatives of an Independent Diagnostic Testing Facility (IDTF) stating that they provide services at a lower cost than hospitals. This is probably a true statement. However, it is important for you and the committee members to understand why this may be possible. IDTFs specifically target one of the most lucrative services provided by hospitals. Imaging services are a major "profit center." Profit centers help hospitals offset the cost of providing unprofitable services 24 hours a day, 365 days a year to all patients who show up on our doorsteps.

COST SHIFTING

Community hospitals serve the community. IDTFs are businesses. IDTFs generally operate during normal business hours Monday through Friday. Consequently, they do not have to bear the additional cost of staffing 24 hours a day nor do they have to keep their doors open during periods of low utilization. Community hospitals, on the other hand, are always open, standing by for the emergency patient or the mother who goes into labor in the middle of the night.

HB511 will not limit competition or stop the development of IDTFs. However, it will eliminate the unfair advantage IDTFs currently have of being able to compete with local community hospitals without having to demonstrate the need for their service. If the CON statute is not changed and the playing field leveled, IDTFs will continue to have this unfair advantage. They will be able to continue carving the profitable services out of hospitals, leaving us with the responsibility of providing unprofitable services with very limited resources. Hospitals will have to raise rates to compensate for the loss of revenue when the profitable services are gone. As a result, the cost of care for everyone in the

Ph 907-235-8101 • Fx 907-235-0253
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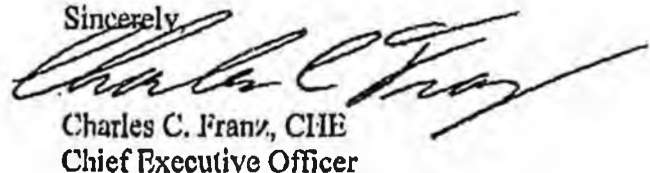
community will go up. Small rural hospitals operate on a very thin margin or no margin with support from local tax dollars. If we lose profitable services and don't raise rates, the community will either lose its hospital or residents will have to provide greater tax subsidies to maintain the hospital.

Healthcare is not a free market activity. At South Peninsula Hospital 86% of the bills are paid by someone other than the patient and 55% are paid by the government either through Medicaid or Medicare. The result of this third party involvement in healthcare payment is that it doesn't really matter what a provider charges for a service. In the majority of the cases, someone else decides what we will be paid.

If the opponents of HB511 are really interested in taking care of patients; providing better, more affordable health care; and not just making money; I respectfully suggest that you ask them why they don't move into a community and set up an emergency room or obstetrics department.

This is not an anti-competition bill. It is a bill that will provide equal treatment under the law. Yes, the CON process does require some additional paperwork to justify an application. However, it is not nearly as burdensome as has been asserted. Please do what is right for your community and others in Alaska; preserve access to care; pass HB511; and correct this inequity.

Sincerely,



Charles C. Franz, CHE
Chief Executive Officer

Cc: Senator Lyda Green
Senator Gary Wilken
Senator Bettye Davis
Senator Gretchen Guess

Northern Gas, LLC

A Full Service Anesthesia Provider
4100 Lake Otis Pkwy., Suite 209
Anchorage, Alaska 99508
Phone (907) 563-3169
Fax (907) 770-1462

Comments:

HB 511 is scheduled for a hearing in Senate HESS today. I urge you to vote no on this bill. This bill aims to stifle competition. Providence and other facilities with current CON are pushing this bill to allow them to avoid market place competition. Physicians, their patients and the community at large know that competition optimizes service and controls cost. This bill is before you today because of a deal arranged between two Anchorage physicians and Providence Hospital. Providence has agreed not to oppose the CON request by these 2 physicians who are planning to build a medical building here in Anchorage in which Providence will be a partner. We can not stand by and allow Providence or any other major market player to monopolize the market in this way. Providence has the money, the attorneys and the political influence to overtake individual practitioners who are busy providing medical care to the community. The physician community needs the help of their legislators to protect them against such high handed tactics. Please vote NO on HB 511.

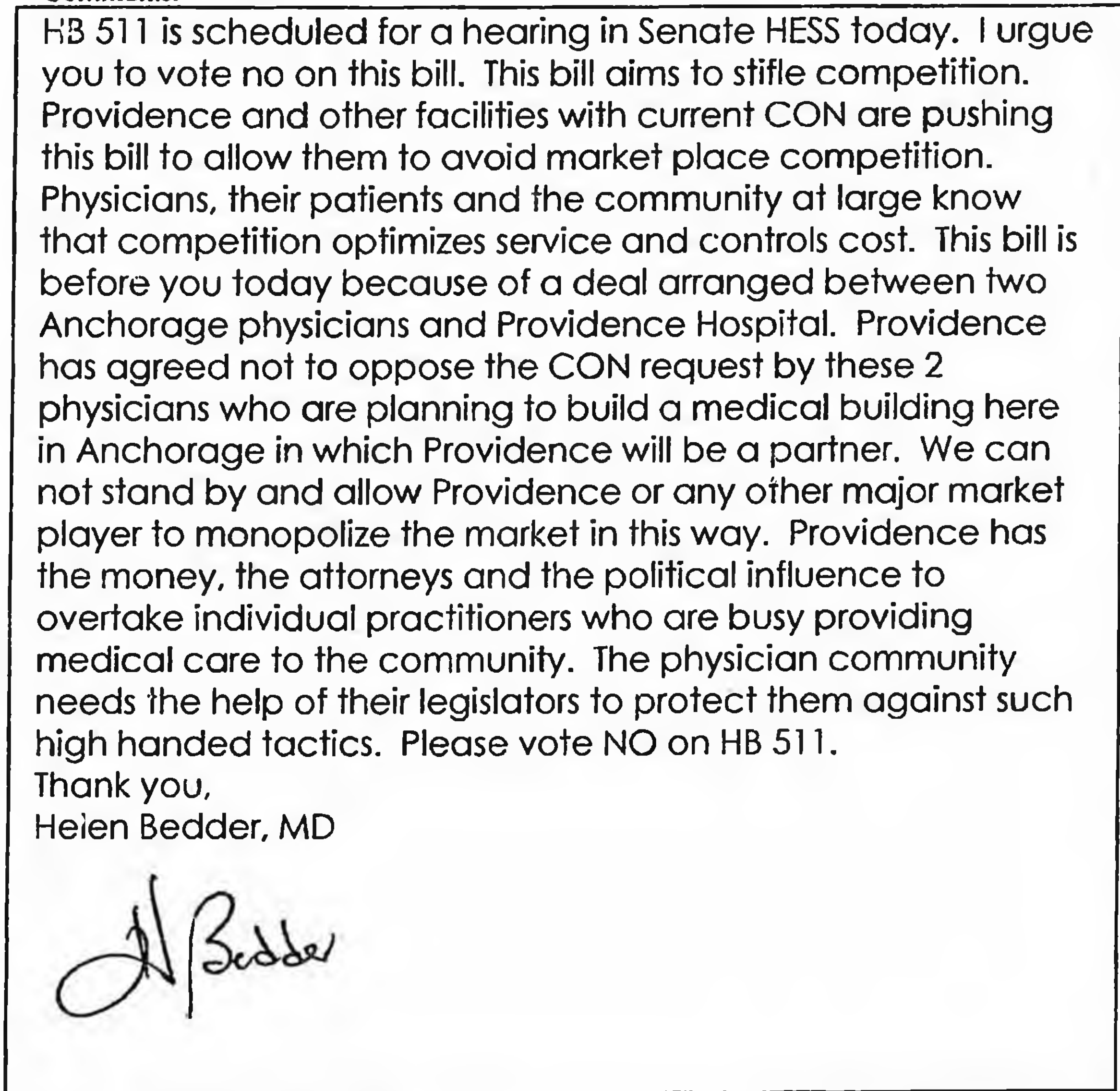
Marshall Redden M.D.
5/3/04

Fax Cover Sheet

7521 Sportsmen's Point Circle
Anchorage, Alaska
99502

Send to: SEN. DYSON	**From: Dr. Helen Bedder**
Attention:	Date: 5/3/04
Fax Number: 907-4587	Fax Number: 907-248-2399
Phone Number:	Phone Number: 907-248-2665

Comments:



HB 511 is scheduled for a hearing in Senate HESS today. I urgue you to vote no on this bill. This bill aims to stifle competition. Providence and other facilities with current CON are pushing this bill to allow them to avoid market place competition. Physicians, their patients and the community at large know that competition optimizes service and controls cost. This bill is before you today because of a deal arranged between two Anchorage physicians and Providence Hospital. Providence has agreed not to oppose the CON request by these 2 physicians who are planning to build a medical building here in Anchorage in which Providence will be a partner. We can not stand by and allow Providence or any other major market player to monopolize the market in this way. Providence has the money, the attorneys and the political influence to overtake individual practitioners who are busy providing medical care to the community. The physician community needs the help of their legislators to protect them against such high handed tactics. Please vote NO on HB 511.

Thank you,

Helen Bedder, MD

H Bedder

Robert F. Valentz MD
P.O. Box 71434
Fairbanks, AK 99707

May 3, 2004

Sent Via Fax

Re: HB 511 - Vote no !!!

Dear Senator:

HB 511 will raise Health Care costs in Alaska by using governmental regulation to eliminate competition among health care facilities. Major corporate hospitals will be the only providers for surgical services and diagnostic imaging studies in the state of Alaska.

Why is this bad ???

Health care cost in Alaska is the highest in the nation. This is due to the fact that there is no competition. Corporations such as Fairbanks Memorial, Providence, and Alaska Regional charge the highest rates in the nation for patients undergoing surgical procedures. HB 511 effectively closes any opportunity for any competitors to emerge in these markets. Consumers will have no choice where to have their surgery done or imaging studies undertaken. These major corporate hospitals will dictate what services will be offered to the community and at what cost.

Why will this occur ?

HB 511 seeks to amend the exemption for the Certificate of Need (CON). Currently, no certificate of need is required if the facility can be built under 1 million dollars. The 1 million exemption amount is unrealistic if the building and equipment are purchased. If the building and equipment are leased, a very small ambulatory surgery could possibly be built. HB 511 seeks to include lease payments in the calculation to determine if an exemption is warranted. The net result will be the elimination of the exemption from a practical standpoint. Fairbanks Memorial, Providence, and Alaska Regional will never have any competition and patients will continue to pay exorbitant health care costs. These high costs are reflected in our insurance premiums and the taxes we pay that fund Medicare and Medicaid.

What the CON really does.

Many states have eliminated CON as a means to deregulate the health care market and allow competition to occur. Deregulation of the telephone industry in the 1980's has provided us with lower long distance charges and a variety of new services unheard of prior to the divesture of AT&T. Maintenance of the CON or effective elimination of the exemption, insures that patients in Alaska will continue to pay the highest amount for their health care services.

Why regulate imaging centers ?

HB 511 also seeks to include imaging centers under the CON requirements. Currently, stand alone imaging centers exist in Alaska which provide the same service at 30% less than major corporate hospitals. Patients have a choice and can save money. Rather than lowering their prices, major corporate hospitals, seek the inclusion of imaging centers into the CON requirements in order to eliminate their competition via legislation.

Overall, HB 511 is an anti-competitive bill designed to profit large corporate hospitals in Alaska. Passage of this bill ensures that Alaskan's will pay the highest cost for their health care and will severely restrict their choice in choosing medical services. I urge you to vote no on HB 511.

Sincerely,

Robert F. Valentz MD

Alaska State Legislature

Please enter into the record my testimony to the *Health Education + Social Services*
committee name

committee on *HB 511*, dated *4/30/04*.
bill/subject

I wish to express my opposition to HB511. This bill, whether by design or accident, will have a detrimental affect upon healthcare options for Alaska residents. Expansion of the Certificate Of Need, as proposed in HB511, will discourage the development of new and expansion of existing healthcare providers in our State. This bill will have the consequence of restricting and reducing choices for medical treatment that Alaskans sorely need. The sky-rocketing cost of medical care, which is one of the most challenging issues throughout Alaska and the country, will become an even greater problem if this bill becomes law. Restricting or impeding business expansion, at a time when the Administration and Legislature is attempting to develop a fiscal plan for our State's economic future, is nothing short of incomprehensible. Government, in Alaska and across our country, must never create unnecessary barriers to free enterprise! Competition always benefits the consumer because it forces businesses to provide better products and services at better prices. HB511, if passed, will have the complete opposite impact. I respectfully request that HB511, and the special interest groups who are focused strictly on their own profits and personal gain, be defeated. Please support expansion of medical care and economic development in Alaska by voting against HB511.

Signed: *[signature] (Ed Brittingham)*
Testifier

Self
Representing (Optional)

P.O. Bx. 672011, Chugiak, AK. 99567
Mailing Address

907-688-5047
Phone Number

Post-it® Fax Note 7671	Date	# of pages ▶ 3
To SENATE HESS	From CHRIS CONOVER	
Co./Dept.	Co.	
Phone # 907 465 4587	Phone # 919 684 8026	
Fax #	Fax # 919 684-6246	

Testimony of
Christopher J. Conover, Ph.D.
Assistant Research Professor of Public Policy Studies
Terry Sanford Institute of Public Policy, Duke University
Before the Committee on Health, Education and Social Services
State of Alaska Senate
1:30 p.m., May 3, 2004

Mr. Chairman and Members of the Committee:

I am Christopher Conover, Assistant Research Professor of Public Policy Studies in the Center for Health Policy, Law and Management, a part of the Terry Sanford Institute of Public Policy at Duke University. Together with Frank Sloan, I have conducted 2 major studies of CON: one for the State of Delaware in 1995-1996 and the most recent for the State of Michigan published in 2003. Professor Sloan and I also co-authored a major article on CON that appeared in the June 1998 Journal of Health Politics, Policy and Law, one of the top-ranked journals in health policy. I very much appreciate the opportunity to testify before the Committee on the important issue of whether to expand CON to include freestanding diagnostic imaging centers.

There are three principal reasons used to justify CON. The most important of these is to control costs by limiting the supply of facilities. A second is to regionalize facilities in order increase the volume of procedures since for some procedures facilities with high volumes tend to have better outcomes, especially for complex surgeries where practice evidently makes perfect. A last reason is to increase access to care by improving the geographic distribution of facilities.

Our report for Michigan systematically reviewed the evidence regarding CON from every published CON study to date. Included among these were six studies that looked at CON's impact on the diffusion of CT scanners and four studies focused on CON's effects on the supply of MRI's.

Evidence Regarding CT Scanners

There is mixed evidence about CON's impact on CT scanners. The consensus view is that the earliest years of CT development largely escaped effective CON regulation because so many states still did not have CON in place when the technology first became available (Hillman and Schwartz 1985). On the contrary, there is at least some evidence that the rapid diffusion of CT in 1975 may have been partly due to anticipatory behavior by hospitals hoping to obtain the technology before CON review was established (Banta 1980). The available studies bear out this largely pessimistic view of CON's effectiveness regarding CT scanners:

- One of the earliest studies, by Paul Joskow (1981), found that neither the existence of CON nor the age of the program had any significant effect on the number of CT scanners acquired in a state nor whether CT scanners were located in a hospital or physician's office.
- A Massachusetts study (Lawthers-Higgins, Taft and Hodgman 1984) found that a CON moratorium on hospital-based CT scanners slowed their diffusion temporarily, but had no overall effect on diffusion in the long run once the moratorium was lifted.

That is, despite strict CON regulation of CT scanners, this technology grew more rapidly in Massachusetts than in the rest of the U.S.

- A study for Ohio by the Lewin Group showed that CON was associated with a decrease in supply of hospital-based CT scanners (Lewin-ICF and Alpha Center 1991).
- Our analysis for the State of Michigan, which goes through the year 2000 and is the most recent available, showed no significant effect on hospital-based CT availability in states that lifted CON compared to states that did not; we also found that stringency of CON had no detectable effect on CT supply (Conover and Sloan 2003).

Even though Lawthers-Higgins are proponents of CON, they acknowledged "there were probably some real noneconomic patient costs of the Massachusetts approach to rationing scanners. These may have included long waits, in addition to the inconvenience and discomfort of having to be transported from a hospital without a scanner to a hospital with one." They also noted that "since limited availability of scanners forced prioritization of patients, some patients who might have benefited from CT were not scanned. Many of the alternatives to scanning involve more risk and discomfort to the patient (e.g., angiography)."

Evidence Regarding MRI Units

The evidence for MRIs also is somewhat mixed, although on balance slightly more favorable to CON:

- Two reports by Lewin Group have found that CON had a significant negative effect on supply of MRI units (Lewin-ICF 1992; Lewin-ICF and Alpha Center 1991).
- Researchers at the Wharton School (Teplensky et al. 1995) looked at CON's impact on hospital decisions about whether to adopt MRI's, finding that whether or not a state had CON regulation of hospital-based MRI's produced no significant effect on adoption. Neither did subjective perceptions about the degree of difficulty of obtaining CON approval for a hospital-based MRI or the degree of difficulty of obtaining CON approval for a non-hospital MRI.
- The only variable that negatively influenced the rate of adoption was the overall stringency of the CON program. For each one-point increase in CON stringency on a 15-point scale, the odds of adoption among hospitals that had not yet acquired MRI decreased by 4.4 percent. Alaska is among 20 states regarded as having a limited stringency CON program.
- Our analysis for the State of Michigan, showed that in states that lifted CON, MRI supply was significantly lower in the years just before CON was dropped than it would have been without CON. Once CON was lifted, this continued to be true, but not by a statistically significant margin, suggesting that MRI supply had grown faster than it would have had CON been retained; likewise we found that stringency of CON resulted in lower MRI supply (Conover and Sloan 2003).

However, an important limitation of all of these studies including our own is that they focus exclusively on hospital-based MRI units. But half of all MRIs are located in physician offices, so it may well be that in states that regulate CON, there simply is faster growth on the physician side and no net effect on MRI supply overall.

Other Observations

A critical shortcoming of all of these studies is that they count numbers of units rather than directly measure costs. This is somewhat equivalent to estimating consumer expenditures on gasoline based on the number filling stations. The presumption in these studies is that more units mean more services, which means higher costs. But the example of gas stations illustrates the potential fallacy of that approach. In the case of gas stations, prices tend to be lower when there are two gas stations competing across the corner from one another even though logically one might think the duplication of facilities would result in higher prices. While medical care is not the same as gasoline, various FTC studies have shown that hospital prices and costs are higher in areas where there is a monopoly provider compared to areas where there is head-to-head competition, which is precisely why they regulate hospital consolidation to prevent anti-competitive effects.

Moreover, even if one could demonstrate that reducing the supply of imaging services results in lower spending on these services, this is not tantamount to proving that regulation has saved money. On the contrary, if imaging is a substitute for more expensive more invasive procedures and/or early imaging can reduce the need for expensive interventions down the road, then saving money on imaging might actually be pennywise and pound foolish.

It is worth noting also that there are no volume benchmarks for CT or MRI services established either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).or the American College of Radiology. So even if CON were effective at holding down CT or MRI supply, there is no good reason to suppose this would confer an improvement in quality of care.

A final thought worth considering is this. Only 21 states now regulate CT scanners, 24 regulate PET scanners and 30 regulate MRIs. Have the states that opted not to regulate these technologies made a foolhardy choice? Are their citizens paying higher costs or enduring lower quality care because these imaging technologies do not fall under CON review? I am aware of no such evidence. Unfortunately, the kind of definitive study that could nail down the answer to the question being considered today has not been done. Such a study is feasible and could be completed in roughly a year's time. Frankly, given the available evidence, I would be more inclined to drop regulation of imaging technology in hospitals than I would be to expand this regulation to non-hospital entities. But the best approach of all might be to do the research that could definitively nail down this question of whether regulating these technologies saves money or adds to costs once all costs are considered. It is not at all clear what harm would be done by deferring a decision for such a modest length of time until the answer to the right question can be determined. I would be happy to answer any questions.

Thank you for your time.

FROM : CHPLM FAX NO. :9196846246 May. 03 2004 07:37PM P1

Post-it® Fax Note 7671 | Date | # of pages ▶ 14
To SENATE HESS | From CHRIS CONOVER
Co./Dept. | Co.
Phone # 907 465-4587 | Phone # 919 684 8026
Fax # | Fax # 919 684-6246

Maternal Behavior during Pregnancy. *Demography* 24:407–412.

Williamson, R. S. 1990. *Reagan's Federalism: His Efforts to Decentralize Government*. Lanham, MD: University Press of America.

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

Christopher J. Conover and Frank A. Sloan
Duke University

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

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

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FROM :CHPLM FAX NO. :9196846246 May. 03 2004 07:37PM P2

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

Several developments have occurred since the late 1960s and early 1970s that have lessened the popularity of CON regulations, especially as they affect hospital care. First, other regulatory mechanisms thought to be more effective in cost containment have been adopted. Primary among these is Medicare's Prospective Payment System (PPS), but some states implemented various forms of regulation of hospital rates and revenue. Although PPS is still in effect, hospital rate-setting remains in only one state.[1] Second, there has been substantial growth in various forms of managed care, stimulated in part by legislation, such as selective contracting laws. Although specific incentives differ, managed care provides incentives for hospitals to be concerned about cost. In this context, there is a perception that CON regulations may not be needed as much as they were previously to control hospital cost growth. As a result of managed care plan growth as well as implementation of PPS, demand for inpatient hospital care has decreased appreciably. Third, as discussed later, a substantial amount of empirical evidence accumulated by the early 1980s indicating that CON regulations were ineffective in cost containment. Research findings per se did not contribute to the demise of CON laws, but such findings probably coincided with experience-based impressions of policy makers and experts in the field. Fourth, the federal law requiring states to have CON regulations expired in 1986. Since then, fifteen states have dropped CON regulations for hospital services; about half of these have retained CON regulations for nursing homes.

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

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

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

FROM :CHPLM FAX NO. :9196846246 May. 03 2004 07:38PM P3

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

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

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

Empirical Specification

Dependent Variables

We specified equations for the following dependent variables. To measure the effects of CON and other factors on per capita health spending, we defined dependent variables for (1) total expenditures on personal health care services; (2) total acute care expenditures (defined as total spending minus nursing and home health expenditures); (3) expenditures on hospital care; and (4) expenditures on physicians' services per person for a state's resident population. We also obtained estimates of Medicare spending per elderly enrollee, including total Medicare expenses and Part A and Part B expenditures.[3] Unpublished estimates of personal health care expenditures by state and year in total and by component were obtained from HCFA for 1980–1993.[4] We also analyzed Medicare expenditures for 1980–1993. All monetarily expressed variables were deflated by the all-items Consumer Price Index.

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

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

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

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

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

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by data availability.[5] Information on the first three variables came from the *Hospital Statistics* (AHA 1977–1994). Data for the fourth came from the SMG Marketing Group (1984–1995). For the variable industry organization, we defined dependent variables for the for-profit share of hospital beds[6] for 1976–1993 based on *Hospital Statistics* and the HMO enrollments as a fraction of the state population, information taken from the Group Health Association of America's *National Directory of HMOs* (GHAA 1977–1994). We used data for 1976–1993 in our analysis of HMO market share.

Examining Certificate-of-Need Laws

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

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

Program age is only one aspect of CON programs that is heterogeneous. Programs also logically differ in *stringency*, which reflects the scope of coverage and the difficulty applicants have in securing certificates of need. In an alternative specification, we used a CON stringency measure originally developed by Lewin-ICF (1992a).[7] These measures took account of dollar thresholds used to determine whether a project was subject to CON review, in terms of the scope of specific categories of services subject to review. This produced a continuous numerical score that Lewin-ICF used to categorize states into three mutually exclusive categories: 1 = limited; 2 = moderate; 3 = stringent. These categorical scores were used in our analysis.[8]

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

Hospital Rate-Setting

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

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

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

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

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

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

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Reimbursement

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

Price Competition

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

Area Characteristics

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

Other Explanatory Variables

To capture omitted cross-sectional and intertemporal influences, we included state binary variables and a time trend. To conserve space, coefficients and standard errors on the intercept, state binary variables, and the Voluntary Effort (only included in analysis that spanned the 1970s but not presented because it is no longer of policy interest) are not presented in the tables shown here.[11] To allow us to distinguish between short- and long-run influences on explanatory variables, we included lagged dependent variables. The coefficient on the dependent variable is interpretable as one minus the fraction of the gap between the actual and the equilibrium value of the dependent variable that is closed in a year (λ). Thus, if the coefficient were .8, .2 of the gap would be closed annually. To obtain the long-run influence, the coefficient on an explanatory variable is divided by λ.

Functional Form

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

Results

Effects of Certificate-of-Need Laws

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

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

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

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

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

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
CERTIFICATE-OF-NEED REGULATION							
Section 1122	.012[b]	−.018[b]	−.001	−.029[c]	−.049[c]	−.090[b]	.053
	(.005)	(.007)	(.010)	(.015)	(.029)	(.045)	(.063)
Young CON	.006	.001	.0002	−.0001	.002	−.013	.041
	(.006)	(.007)	(.010)	(.015)	(.029)	(.045)	(.064)
Mature CON	−.004	−.009[b]	−.005	.004	.029[c]	−.008	.163[a]
	(.003)	(.004)	(.006)	(.009)	(.017)	(.027)	(.038)
CON Lifted	−.004	−.006[c]	.010[c]	.003	.032[c]	.017	.143[a]
	(.003)	(.004)	(.006)	(.009)	(.017)	(.026)	(.038)
HOSPITAL RATE-SETTING							
Prospective Payment System (PPS)	.042[a]	.013	.091[a]	.103[b]	−.254[a]	−.401[a]	.169
	(.016)	(.022)	(.031)	(.045)	(.083)	(.128)	(.182)
Young Mandatory Prospective	−.038[b]	.036[c]	−.063[b]	−.065[c]	.051	−.024	.253
	(.015)	(.021)	(.029)	(.040)	(.082)	(.126)	(.178)
Old Mandatory Prospective	.011[c]	−.017[c]	−.022[c]	−.027[c]	−.073[b]	−.101[c]	−.052
	(.006)	(.009)	(.012)	(.018)	(.034)	(.053)	(.075)
REIMBURSEMENT							
Medicaid Share	.059[a]	.082[a]	.153[a]	−.039	.125	.330[c]	−.322
	(.022)	(.030)	(.042)	(.063)	(.120)	(.185)	(.261)
Medicare Share	−.179[a]	.204[a]	−.330[a]	−.092[b]	.008	.124	−.246
	(.017)	(.023)	(.033)	(.047)	(.089)	(.139)	(.193)
COMPETITION							
HMO Market Shares	.033	.011	.041	.031	−.178	−.330[c]	−.420
	(.025)	(.034)	(.049)	(.072)	(.137)	(.208)	(.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
AREA CHARACTERISTICS							
Income Per Capita	.006	.002	.011	.071[b]	−.249[a]	−.168[c]	−.513[a]
	(.012)	(.016)	(.023)	(.034)	(.065)	(.099)	(.141)
General Practitioner	.061[a]	.089[a]	.088[a]	.019	.442[a]	.521[a]	.599[a]
	(.016)	(.021)	(.030)	(.044)	(.084)	(.129)	(.183)
All Physicians	−.008	-.001	.069[c]	.135[b]	.412[a]	.334[c]	1.081[a]
	(.026)	(.033)	(.046)	(.067)	(.128)	(.197)	(.272)
Elderly	.065[a]	.100[a]	.051	.054	−.085	−.163	.207
	(.021)	(.028)	(.039)	(.059)	(.112)	(.172)	(.243)
Density	−.087[a]	−.127[a]	−.079[a]	.003	−.087	−.112	−.171
	(.016)	(.021)	(.030)	(.045)	(.085)	(.131)	(.186)
Service Wage	.046[a]	.045[b]	−.122[a]	.218[a]	.101[c]	.230[b]	−.053
	(.013)	(.018)	(.025)	(.038)	(.070)	(.108)	(.152)
OTHER							
Lagged Dependent	.847[a]	.815[a]	.732[a]	.508[a]	.458[a]	.358[a]	.105[b]
	(.022)	(.026)	(.030)	(.036)	(.034)	(.044)	(.042)
Time	.008[a]	.012[a]	.016[a]	.034[a]	.035[a]	.041[a]	.068[a]
	(.002)	(.002)	(.003)	(.003)	(.004)	(.006)	(.009)
R^2	.998	.997	.993	.989	.993	.985	.970
R^2(C)	.998	.997	.992	.988	.993	.983	.967
F	4547	2693	1136	770	1259	536	275
N	623	623	623	623	623	623	623

[a] Significant at the 1 percent level (two-tail test).
[b] Significant at the 5 percent level (two-tail test).
[c] Significant at the 10 percent level (two-tail test).

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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.

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Table 2 Hospital Beds, "Intensity," and Profitability

		Intensity		
	Beds per 1,000 Population	Expense per Adjusted Patient Day	Expense per Adjusted Admission	Hospital Profits
CERTIFICATE-OF-NEED REGULATION				
Section 1122	–.0004	–.007	–.002	–.272[b]
	(.008)	(.012)	(.009)	(.130)
Pre-CON	–.002	.007	.003	.263[a]
	(.006)	(.009)	(.007)	(.101)
Young CON	–.007	.006	.007	.256[a]
	(.006)	(.008)	(.006)	(.093)
Mature CON	–.008[c]	.011[c]	.010[b]	.153[b]
	(.004)	(.006)	(.005)	(.069)
CON Lifted	.002	–.001	.004	.018
	(.005)	(.008)	(.006)	(.065)
HOSPITAL RATE-SETTING				
Prospective Payment System (PPS)	–.095[a]	–.125[a]	–.105[a]	–.395
	(.025)	(.035)	(.027)	(.400)
Young Mandatory Prospective	.005	.027	.038[c]	–.130
	(.018)	(.026)	(.020)	(.382)
Old Mandatory Prospective	.006	–.003	.005	.157
	(.010)	(.014)	(.011)	(.173)
REIMBURSEMENT				
Medicaid Share	.129[a]	.081[c]	.176[a]	–.689
	(.037)	(.053)	(.041)	(.613)
Medicare Share	.003	.171[a]	.049[c]	2.020[a]
	(.023)	(.034)	(.026)	(.388)
COMPETITION				
HMO Market Shares	–.111[a]	–.003	–.186[a]	–.897[c]
	(.041)	(.054)	(.045)	(.604)
AREA CHARACTERISTICS				
Income Per Capita	–.044[b]	.021	.004	–.019
	(.018)	(.025)	(.019)	(.306)
General Practitioner	.042[b]	.032	.026	–.062
	(.017)	(.024)	(.019)	(.290)
All Physicians	.215[a]	–.002	.097[a]	–1.096[b]
	(.029)	(.044)	(.033)	(.469)
Elderly	.100[a]	–.019	–.070[b]	–.268
	(.026)	(.036)	(.028)	(.414)
Density	–.024	–.005	.066[a]	–.125
	(.020)	(.029)	(.022)	(.312)
Service Wage	–.032[c]	.124[a]	.032[c]	1.175[a]
	(.020)	(.028)	(.022)	(.320)
OTHER				
Lagged Dependent	.616[a]	.803[a]	.801[a]	.318[a]
	(.021)	(.023)	(.021)	(.033)
Time	–.007[a]	.009[a]	.006[a]	.075[a]
	(.001)	(.002)	(.001)	(.017)
R^2	.986	.986	.990	.621
$R^2(C)$	.985	.984	.989	.586
F	818	802	1178	18
N	863	863	863	818

[a] Significant at the 1 percent level (two-tail test).
[b] Significant at the 5 percent level (two-tail test).
[c] 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

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Table 3 Diffusion of Technology

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

Table 3 Continued

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

[a] Significant at the 1 percent level (two-tail test).
[b] Significant at the 5 percent level (two-tail test).
[c] Significant at the 10 percent level (two-tail test).

data to assess the impact of CON. Examining data through 1982, Lanning, Morrisey, 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.

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Table 4 Industry Organization

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

Table 4 Continued

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

[a] Significant at the 1 percent level (two-tail test).
[b] Significant at the 5 percent level (two-tail test).
[c] 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 a 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 re[illegible]

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

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

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

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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

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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.

References

American Hospital Association (AHA). 1977–1994. *Hospital Statistics* (annual). Chicago: AHA.

Anderson, Gerard F., Judith R. Lave, Catherine M. Russe, and Patricia Neumann. 1989. *Providing Hospital Services: The Changing Financial Environment.* Baltimore, MD: Johns Hopkins University Press.

Antel, John J., Robert L. Ohsfeldt, and Edmund R. Becker. 1995. State Regulation and Hospital Costs. *Review of Economics and Statistics* 77(3):416–422.

Ashby, John L. 1984. The Impact of Hospital Regulatory Programs on per Capita Costs, Utilization, and Capital Investment. *Inquiry* 21(1):45–59.

Begley, Charles E., Milton Schoeman, and Herbert Traxler. 1982. Factors That May Explain Interstate Differences in Certificate-of-Need Decisions. *Health Care Financing Review* 3(4):87–94.

Biles, Brian, Carl Shramm, and J. Graham Atkinson. 1980. Hospital Cost Inflation under State Rate-Setting Programs. *New England Journal of Medicine* 303(12): 664–668.

Billings, John, Lisa Zeitel, Joanne Lukomnik, Timothy S. Carey, Arthur E. Blank, and Laurie Newman. 1993. Impact of Socioeconomic Status on Hospital Use in New York City. *Health Affairs* 12(1):162–173.

Bureau of Labor Statistics (BLS). 1976–1994. *Employment and Earnings* (monthly). Washington, DC: Government Printing Office.

Campbell, Ellen S., and Melissa W. Ahern. 1993. Have Procompetitive Changes Altered Hospital Provision of Indigent Care? *Health Economics* 2(3):281–289.

Campbell, Ellen S., and Gary M. Fournier. 1993. Certificate-of-Need Deregulation and Indigent Hospital Care. *Journal of Health Politics, Policy and Law* 18(4):905–925.

Dranove, David, Mark Shanley, and Carol Simon. 1992. Is Hospital Competition Wasteful? *Rand Journal of Economics* 23(2):247–261.

Eastaugh, Steven R. 1982. The Effectiveness of Community-Based Hospital Planning: Some Recent Evidence. *Applied Economics* 14(5):475–490.

Farley, Dean E., and Joyce V. Kelly. 1985. *The Determinants of Hospitals' Financial Positions.* Rockville, MD: National Center for Health Services Research.

Feldstein, Paul J. 1988. *Health Care Economics.* 3d ed. New York: Wiley.

Feldstein, Paul J., and Thomas M. Wickizer. 1995. Analysis of Private Health Insurance Premium Growth Rates: 1982–1992. *Medical Care* 33(10):1035–1050.

Finkler, Merton D. 1985. Changes in Certificate-of-Need Laws: Read the Fine Print. In *Incentive versus Controls in Health Policy: Broadening the Debate*, ed. Jack A. Meyer. Washington, DC: American Enterprise Institute.

———. 1987. State Rate Setting Revisited. *Health Affairs* 6(4):82–89.

Ford, Jon M., and David L. Kaserman. 1993. Certificate-of-Need Regulation and Entry: Evidence from the Dialysis Industry. *Southern Economic Journal* 59(4): 783–791.

Ginsburg, Paul B., and Daniel M. Koretz. 1983. Bed Availability and Hospital Utilization: Estimates of the Roemer Effect. *Health Care Financial Review* 5(1):87–92.

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Group Health Association of America (GHAA). 1977–1994. *National Directory of HMOS* (annual). Washington, DC: GHAA.

Hatanaka, Michio. 1974. An Efficient Estimator for the Dynamic Adjustment Model with Autocorrelated Errors. *Journal of Econometrics* 2(3):99–220.

Joskow, Paul L. 1980. The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital. *Bell Journal of Economics* 11(2):421–444.

Kuttner, Robert. 1996. Columbia/HCA and the Resurgence of the For-Profit Hospital Business. *New England Journal of Medicine* 335(5):362–367.

Lanning, Joyce A., Michael Morrisey, and Robert L. Ohsfeldt. 1991. Endogenous Hospital Regulation and Its Effects on Hospital and Nonhospital Expenditures. *Journal of Regulatory Economics* 3(2):137–154.

Lewin-ICF. 1992a. *Appendix I: Econometric Analysis of CON in Pennsylvania*, by Judith Arnold and Daniel Mendelson. Washington, DC: Lewin-ICF.

Lewin-ICF. 1992b. *Evaluation of the Pennsylvania Certificate-of-Need Program*, by Judith Arnold and Daniel Mendelson. Washington, DC: Lewin-ICF.

Lewin-ICF and Alpha Center. 1991. *Evaluation of the Ohio Certificate-of-Need Program*. Washington, DC: Lewin-ICF.

Lewin-VHI, Inc. 1995. *Potential Cost Shifting under Proposed Funding Reductions for Medicare and Medicaid: Final Report Prepared for the National Leadership Coalition on Health Care*, by John F. Sheils and David J. Ricks. Washington, DC: Lewin-VHI.

Luft, Harold S., Deborah W. Garnick, David H. Mark, and Stephen J. McPhee. 1990. *Hospital Volume and Patient Outcomes: Assessing the Evidence*. Ann Arbor, MI: Health Administration.

Morrisey, Michael A., Frank A. Sloan, and Samuel A. Mitchell. 1983. State Rate Setting: An Analysis of Some Unresolved Issues. *Health Affairs* 2(2):36–47.

Noether, Monica. 1988. Competition among Hospitals. *Journal of Health Economics* 7(3):259–284.

Policy Analysis, Inc., and Urban Systems Research and Engineering, Inc. (PAI-US). 1980. *Evaluation of the Effects of Certificate-of-Need Programs*. Vol. 1, *Executive Summary*. Washington, DC: U.S. Department of Health and Human Services, Health Resources Administration, Bureau of Health Planning and Resources Development.

Robinson, James C. 1995. Health Care Purchasing and Market Changes in California. *Health Affairs* 14(4):118–130.

Robinson, James, and Harold Luft. 1987. Competition and the Cost of Hospital Care, 1972–1982. *Journal of the American Medical Association* 257(23):3241–3245.

Rosko, Michael D. 1989. A Comparison of Hospital Performance under the Partial-Payer Medicare PPS and State All-Payer Rate-Setting Systems. *Inquiry* 26(1): 48–61.

Russell, Louise B. 1979. Regulating the Diffusion of Hospital Technologies. *Law and Contemporary Problems* 43(1):26–42.

Salkever, David S., and Thomas W. Bice. 1976. The Impact of Certificate-of-Need Controls on Hospital Investment. *Milbank Quarterly* 54(2):185–214.

———. 1979. *Hospital Certificate-of-Need Controls: Impact on Investments, Costs, and Use*. Washington, DC: American Enterprise Institute for Public Policy Research.

Sherman, Daniel. 1988. *The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis*. Washington, DC: U.S. Federal Trade Commission, Bureau of Economics.

Shortell, Stephen M., and Edward F. X. Hughes. 1988. The Effects of Regulation, Competition, and Ownership on Mortality Rates among Hospital Inpatients. *New England Journal of Medicine* 318(17):1100–1107.

Simpson, James B. 1986. Full Circle: The Return of Certificate-of-Need Regulation of Health Facilities to State Control. *Indiana Law Review* 19(4):1025–1127.

Sloan, Frank A. 1981. Regulation and the Rising Cost of Hospital Care. *Review of Economics and Statistics* 63(4):479–487.

———. 1983. Rate Regulation as a Strategy for Hospital Cost Control: Evidence from the Last Decade. *Milbank Quarterly* 61(2):195–221.

———. 1988. Property Rights in the Hospital Industry. In *Health Care in America: The Political Economy of Hospitals*, ed. Harold E. Frech, III. San Francisco: Pacific Research Institute for Public Policy.

Sloan, Frank A., and Bruce Steinwald. 1980a. Effects of Regulation on Hospital Costs and Input Use. *Journal of Law and Economics* 23(1):81–109.

———. 1980b. *Insurance, Regulation, and Hospital Costs*. Lexington, MA: D. C. Heath.

Sloan, Frank A., Joseph Valvona, James M. Perrin, and Killard W. Adamache. 1986. Diffusion of Surgical Technology: An Exploratory Study. *Journal of Health Economics* 5(1):31–61.

SMG Marketing Group. 1984–1995. *Freestanding Outpatient Surgery Centers: Report and Directory* (annual). Chicago: SMG Marketing Group.

Teplensky, Jill D., Mark V. Pauly, John R. Kimberly, Alan L. Hillman, and J. Sanford Schwartz. 1995. Hospital Adoption of Medical Technology: An Empirical Test of Alternative Models. *Health Services Research* 30(3):437–465.

Wedig, Gerard, Mahmud Hassan, and Frank Sloan. 1989. Hospital Investment Decisions and the Cost of Capital. *Journal of Business* 62(4):517–536.

Wendling, Wayne, and Jack Werner. 1980. Nonprofit Firms and the Economic Theory of Regulation. *Quarterly Review of Economics and Business* 20(3):6–18.

Wholey, Douglas, Roger Feldman, and Jon B. Christianson. 1995. The Effect of Market Structure on HMO Premiums. *Journal of Health Economics* 14(1):81–105.

Zwanziger, Jack, and Glenn A. Melnick. 1996. Can Managed Care Plans Control Health Care Costs? *Health Affairs* 15(2):186–199.

May 4, 2004

Senator Fred Dyson
Alaska State Senate

RE: House Bill 511

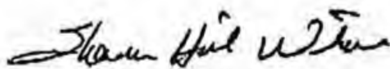
Honorable Senator Dyson,

I am writing this letter in order to express my opposition to House Bill 511 "Certificate of Need". I believe that this bill will restrict access to care for Alaskans and negatively affect the quality of care delivered in our state.

The small business entrepreneur and free enterprise is the backbone of our country. Competition is what drives our market and fosters lower prices. I believe that the proposed legislation limits the abilities of the previous mentioned and fosters monopolies for major health care institutions. I believe that this will not save healthcare dollars but mandate higher charges because of the lack of competition.

Furthermore, I believe that HB511 will restrict access to care and new technologies. As a patient, quality care, utilization of the most recent and useful technologies, and reasonable cost are important issues. Competition in all of these areas drives the providers of the services to excel and promotes change. These are good things, which are restricted with the proposed "Certificate of Need" legislation in HB511. It is not in the best interest of healthcare consumers. Truly, this should be the goal of this legislation.

I am adamantly against HB511 and respectfully request that you consider these issues when reviewing HB511.



Shawna Hill Wilson
Family Nurse Practitioner

Certificate of Need, CON, was Federally mandated in 1974 in an attempt to control health care costs in the US. Since its inception, many studies have been undertaken to assess the effect of this legislation on the cost of health care. None of the studies have shown that CON controls cost. What has been shown is that CON reduces competition. In separate studies, economists Mark Pauly and Frank Sloan found that physician prices are higher where hospital beds and nursing resources are limited. William Custer found that, where hospitals are more competitive, physician prices are lower.

Restraint of trade and monopolies are illegal in the state of Alaska.

AS 45.50.562 "...combinations in restraint of trade are unlawful"
AS 45.50.564 "...monopolies and attempted monopolies are unlawful

The Alaska Supreme Court has held that the right to engage in economic endeavors is "an important right" under the Alaska Constitution's equal protection clause; and, the court must closely scrutinize legislative enactments, which interfere with that right. (*Matson* v. *Commercial fisheries Entry Commission, 785 P.2d 1200,1205. Alaska 1990)*

House bill 511 prevents competition and creates a monopoly. This monopoly distorts the market in health care just as monopolies distort the market in other areas. Multiple studies have been conducted to assess the effect of CON on the market. Some of these are discussed below.

Commissioned by the State of Michigan, the Center for Health Policy, Law and Management produced a report based on a five-month study to evaluate the Certificate of Need Program in Michigan. Christopher Conover, PhD served as principal investigator and Frank Sloan PhD served as a consultant. Both are nationally recognized experts in this filed.

In their findings, they recognize the sweeping changes that are continuing to occur both in the evolution of medical technology as well as in health care delivery and financing. They believe that the strong market forces being ushered in by these changes offer considerable potential for curbing costs. Their study concludes that "With its roots in the rapidly disappearing cost-based, third party reimbursement mechanisms of the past, CON is becoming clearly less relevant as a cost containment mechanism. Primary justification for CON, therefore, must rest on its ability to improve or maintain quality and /or access to care."

They also found that upon reviewing a large body of national and Michigan-specific material regarding acute care CON, including an analysis of what happened in states that dropped acute care CON that:

- "There is little evidence that CON results in a reduction in costs and some evidence to suggest the opposite;
- Removal of CON does not consistently lead to a "surge" in either acquisition of new facilities or medical expenditures;"

In January of 1999, the State of Washington authorized a joint legislative audit and review committee study of the effects of Certificate of Need. The main purpose of Washington's CON program was to "... restrain health care costs by regulating the supply of services and facilities..." The findings of the study were based on an analysis of other states' experiences and by informed views of individuals and organizations in Washington's health system.

"COST
The study found strong evidence that CON is not an effective mechanism for controlling overall health care spending. In addition, CON has not been very effective in controlling hospital costs. The study also found that CON has restricted the supply of some specific services and that the repeal of CON has been associated with supply surges in some states. The study found no convincing evidence that CON programs restrict the growth of managed care."

"QUALITY
Evidence about the effect of CON on quality is inconclusive. The evidence is weak regarding the ability of CON to improve quality by concentrating volume of specialized services...."

"ACCESS
Conflicting evidence was found regarding the effect of CON or its repeal on access to health services. In some instances, CON has been used to protect existing facilities in inner city areas or to prompt providers to locate in those areas. In other instances, CON appears to restrict access by preventing the development of new facilities"

"RURAL CARE
Weak and conflicting evidence was found regarding the effect of CON on access to services in rural areas. One analysis showed that CON did not affect the development of rural networks. Repeal of CON appears to have had no effect in some states, while at least one state has experienced some disruption of rural health care after repeal."

A summer of 2002 article entitled *The Competitive Revolution* appearing in *Health and Medicine,* authored by H.E. Frech, a professor of economics at the University of California at Santa Barbara, discusses, in depth, the changes which have occurred in health care delivery and reimbursement in the recent past. In this article he discusses the issues that gave rise to CON, which had been instituted in several states and then mandated by Congress for all states in 1974. The reason given for instituting CON was to save costs. However, as stated in his article, the underlying reason was to avoid competition. Studies done by many states have shown that the cost savings anticipated by CON regulation have not been realized. Most states have now done away with CON because these regulations have been widely shown to be ineffective in controlling costs. Frech cautions that "...the immediate challenge is to protect the competitive revolution in health plans and health care" and that "...the biggest current threats come from

state mandates." He also states "...any new legislation should reduce competition as little as possible."

In summary,

- CON was introduced to reduce health care costs
- The effect of CON has been to restrict competition in health care
- Competition, where it exists, has been shown to reduce cost and improve quality of service.
- This bill, as all other CON bills in other states, will not have the desired effect of reducing cost.
- Alaska is a state that prides itself on an entrepreneurial spirit. This state promotes economic growth. This state has had a major problem with access to good quality health care facilities and providers. This bill will further enable the monopolies, which exist in this state; it will reduce competition and thus quality will decline and costs will rise and entrepreneurs in medicine will be driven out of the state.

Fax Cover Sheet

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Send to: Senator Dyson	From: Dr. Helen Bedder
Attention:	Date: 5/4/04
Fax Number: 907 465 4587	Fax Number: 907-248-2399
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Please read

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* ADMITTED IN VIRGINIA AND ALASKA

** ADMITTED IN VIRGINIA, WASHINGTON, D.C. AND ALASKA

ALL OTHERS ADMITTED IN ALASKA

May 4, 2004

Senator Fred Dyson, Chairman
Health, Education & Social Services Committee
Alaska State Legislature
State Capital (MS 3100)
Juneau, AK 99801-1182

Re: HB 511

Dear Senator Dyson:

Thank you for giving me the opportunity to testify regarding HB 511 on Monday, May 3, 2004. Please consider this letter as a supplement to my testimony.

As you know, I represent The Lord's Ranch, a non-profit organization located in Warm Springs, Arkansas, and Arkansas Counseling, Inc. My clients have also formed Alaska Counseling, Inc. and Alaska Rehabilitation, LLC (hereinafter "clients") to provide counseling services to children in the State of Alaska. My clients are presently attempting to construct a 30-bed residential psychiatric treatment center for children in the Kenai area.

After I testified on Monday, Commissioner Gilbertson testified that the Department of Health and Social Services would consider four (4) factors in determining whether a residential psychiatric treatment center would be grandfathered under HB 511 and not be required to obtain a Certificate of Need (hereinafter "CON"). These factors are:

1) Construction on the center has started;
2) Fully completed architectural plans;
3) A building permit has been issued; and
4) The construction could be completed within two (2) years after breaking ground.

Unfortunately, my clients would not qualify under these four standards and would be required to miss this year's construction season in order to apply for a CON. Our problem is that the Governor would probably sign HB 511 in the middle of June, 2004. Section 9 of the Bill would make it effective immediately upon the Governor's signature. We would probably not be able to break ground by June 2004 because of the delay in acquiring the property from the City of Kenai. We are hopeful that we will be able to break ground in the latter part of July or early August.

We therefore request that Section 9 of HB 511 be amended to make the effective date October 1, 2004. This amendment would allow my clients to go forward with the construction of the facility this year if possible. On the other hand, if they were not able to break ground and begin construction by October 2004, my clients then would be willing to apply for th CON with the Department. In that event, there should be sufficient time to complete the CON process before the next construction season.

I would appreciate your support in considering such an amendment. Thank you for your consideration.

Very truly yours,

Blaine D. Gilman

BDG: trf
cc: Client

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House bill 511 prevents competition and creates a monopoly. This monopoly distorts the market in health care just as monopolies distort the market in other areas. Multiple studies have been conducted to assess the effect of CON on the market. Some of these are discussed below.

Commissioned by the State of Michigan, the Center for Health Policy, Law and Management produced a report based on a five-month study to evaluate the Certificate of Need Program in Michigan. Christopher Conover, PhD served as principal investigator and Frank Sloan PhD served as a consultant. Both are nationally recognized expert in this filed.

In their findings, they recognize the sweeping changes that are continuing to occur both in the evolution of medical technology as well as in health care delivery and financing. They believe that the strong market forces being ushered in by these changes offer considerable potential for curbing costs. Their study concludes that "With its roots in the rapidly disappearing cost-based, third party reimbursement mechanisms of the past, CON is becoming clearly less relevant as a cost containment mechanism. Primary justification for CON, therefore, must rest on its ability to improve or maintain quality and /or access to care."

They also found that upon reviewing a large body of national and Michigan-specific material regarding acute care CON, including an analysis of what happened in states that dropped acute care CON that:

- "There is little evidence that CON results in a reduction in costs and some evidence to suggest the opposite;
- Removal of CON does not consistently lead to a "surge" in either acquisition of new facilities or medical expenditures;"

In January of 1999, the State of Washington authorized a joint legislative audit and review committee study of the effects of Certificate of Need. The main purposes of Washington's CON program was to "... restrain health care costs by regulating the supply of services and facilities..." The findings of the study were based on an analysis of other states' experiences and by informed views of individuals and organizations in Washington's health system.

"COST
The study found strong evidence that CON is not an effective mechanism for controlling overall health care spending. In addition, CON has not been very effective in controlling hospital costs. The study also found that CON has restricted the supply of some specific servic and that the repeal of CON has been associated with supply surges in some states. The study found no convincing evidence that CON programs restrict the growth of managed care."

"QUALITY
Evidence about the effect of CON on quality is inconclusive. The evidence is weak regarding the ability of CON to improve quality by concentrating volume of specialized services...."

"ACCESS
Conflicting evidence was found regarding the effect of CON or its repeal on access to health services. In some instances, CON has been used to protect existing facilities in inner city areas or to prompt providers to locate in those areas. In other instances, CON appears to restrict access by preventing the development of new facilities"

"RURAL CARE
Weak and conflicting evidence was found regarding the effect of CON on access to services in rural areas. One analysis showed that CON did not affect the development of rural networks. Repeal of CON appears to have had no effect in some states, while at least one state has experienced some disruption of rural health care after repeal."

A summer of 2002 article entitled *The Competitive Revolution* appearing in *Health and Medicine,* authored by H.E. Frech, a professor of economics at the University of California at Santa Barbara, discusses, in depth, the changes which have occurred in health care delivery and reimbursement in the recent past. In this article he discusses the issues that gave rise to CON, which had been instituted in several states and then mandated by Congress for all states in 1974. The reason given for instituting CON was to save costs. However, as stated in his article, the underlying reason was to avoid competition. Studies done by many states have shown that the cost savings anticipated by CON regulation have not been realized. Most states have now done away with CON because these regulations have been widely shown to be ineffective in controlling costs. Frech cautions that "...the immediate challenge is to protect the competitive revolution in health plans and health care" and that "...the biggest current threats come from

state mandates." He also states "...any new legislation should reduce competition as little as possible."

In summary,

- CON was introduced to reduce health care costs
- The effect of CON has been to restrict competition in health care
- Competition, where it exists, has been shown to reduce cost and improve quality of service.
- This bill, as all other CON bills in other states, will not have the desired effect of reducing cost.
- Alaska is a state that prides itself on an entrepreneurial spirit. This state promotes economic growth. This state has had a major problem with access to good quality health care facilities and providers. This bill will further enable the monopolies, which exist in this state; it will reduce competition and thus quality will decline and costs will rise and will entrepreneurs in medicine will be driven out of the state.

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May 5, 2004

Re: HB 511

Dear Senators:

Passage of HB 511 would represent poor public policy by further enhancement of presen' 'ealth care monopolies. As it stands now—certificate of need review is at a $1,000,000.00 threshold in capital expense. HB 511 would capitalize operating and space leasing further encumbering the CON threshold—the net effort will be to reduce the type and number of new facilities to provide advanced ambulatory care.

Monopolies have never served the citizen of this state well: from fish t[illegible]s in territorial days—to hospital cartels in the statehood era. The net effect continues to be uncontrolled costs, decreased availability and reduced access to technology.

A reminder is the analogy of the AT&T monopoly, which was a bloated expensive communication system. Since the break up of AT&T and the competitive environment there has been increased access to communications, improved technology and reduced cost to the consumer over a very short period of time.

Sections 2(d) 2(e) and 4(8) should be removed from this bill or the threshold should be expanded to $5,000,000.00.

Sincerely,

J. Michael James, M.D.

AMENDMENT 3

To CS HB 511 am (H)

To the Letter of Intent

It is the intent of the legislature that the Commissioner of the Department of Health and Social Services convene a task force to review existing Certificate of Need procedures and standards. The task force shall identify measures to improve the efficiency and effectiveness of the Certificate of Need Program. The task force shall include members who represent a broad range of health care facilities [and] , providers and representatives with a background in health care policy development. The task force will report its findings and recommendations directly to the Commissioner.

It is further the intent of the legislature that the Commissioner of the Department of Health and Social Services move expeditiously to update Certificate of Need regulations, policies and procedures including developing standards including those for concurrent review, the public release of documents under the certificate of need program, and time lines regarding the certificate of need process. In so doing, the Commissioner shall fully consider the recommendations of the Certificate of Need task force.

23-LS1755\SA.2
Mischel
5/4/04

AMENDMENT 1

OFFERED IN THE SENATE — BY SENATOR DYSON

TO: CSHB 511(HES) am

1 Page 2, line 1:
2 Delete "new subsections"
3 Insert "a new subsection"
4
5 Page 2, lines 2 - 3:
6 Delete all material.
7
8 Page 2, line 4:
9 Delete "(e)"
10 Insert "(d)"
11
12 Page 5, line 10:
13 Delete "and (e)"
14 Delete "apply"
15 Insert "applies"

L

AMENDMENT 2

Senator Davis

OFFERED IN SENATE HESS

TO: HB 511

Page 5, Line 16:

Add:

(c) AS 18.07.043, enacted by sec. 4 of this Act, does not apply to a health care facility that is under construction on the effective date of this Act if

(1) the health care facility is in compliance with all applicable requirements; and
(2) the health care facility's project under construction
  (A) includes completed architectural plans approved by the applicable authority;
  (B) has acquired a building permit;
  (C) has begun the construction of the building's foundation; and
  (D) will be completed within two years of the effective date of this Act.

23-LS1755\SA.9
Mischel
5/5/04

AMENDMENT

OFFERED IN THE SENATE
TO: CSHB 511(HES) am

1 Page 2, line 1:
2 Delete "new subsections"
3 Insert "a new subsection"
4
5 Page 2, lines 4 - 5:
6 Delete all material.
7
8 Page 4, line 26:
9 Delete "a new paragraph"
10 Insert "new paragraphs"
11
12 Page 4, line 27, following "(10)":
13 Insert ""expenditure" means a payment made for one or more purposes described
14 under AS 18.07.031 and includes the purchase of property occupied by or the equipment
15 required for the health care facility and the net present value of a lease for space occupied by
16 or the equipment required for the health care facility; "expenditure" does not include costs
17 associated with routine maintenance and replacement of equipment at an existing health care
18 facility;
19 (11)"
20
21 Page 5, line 10:
22 Delete "and (e)"
23 Delete "apply"

1 Insert "applies"

23-LS1755\SA.5
Mischel
5/5/04

AMENDMENT 2

OFFERED IN THE SENATE

BY SENATOR DYSON DAVIS

TO: CSHB 511(HES) am

1 Page 5, following line 15:

2 Insert a new subsection to read:

3 "(c) AS 18.07.043, enacted by sec. 4 of this Act, does not apply to a health

4 care facility that is a residential psychiatric treatment center that is under construction

5 before the effective date of this Act if the facility is in compliance with all other applicable

6 federal, state, and local laws. For purposes of this subsection, "under construction"

7 means that

8 (1) the owner of the facility has for the facility

9 (A) complete architectural plans approved by the applicable

10 agency;

11 (B) a building permit;

12 (2) the foundation of the facility is being or has been laid; and

13 (3) the construction of the facility is completed within two years after

14 the effective date of this Act."

L

23-LS1755\SA.1
Mischel
5/4/04

AMENDMENT

OFFERED IN THE SENATE BY SENATOR DYSON

TO: CSHB 511(HES) am

1 Page 1, following line 3:

2 Insert a new bill section to read:

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

4 (a) Except as provided in (c) of this section, a person may not make an

5 expenditure of **$3,000,000** [$1,000,000] or more for any of the following unless

6 authorized under the terms of a certificate of need issued by the department:

7 (1) construction of a health care facility;

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

9 (3) addition of a category of health services provided by a health care

10 facility."

11

12 Page 1, line 4:

13 Delete "**Section 1.**"

14 Insert "**Sec. 2.**"

15

16 Renumber the following bill sections accordingly.

17

18 Page 5, line 10:

19 Delete "sec. 2"

20 Insert "sec. 3"

21

22 Page 5, line 13:

23 Delete "secs. 3 and 5"

1 Insert "secs. 4 and 6"