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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

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

Table 1 Continued

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

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

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

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

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

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

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

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

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

Hospital Rate-Setting

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

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

Price Competition

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

Table 2 Hospital Beds, "Intensity," and Profitability

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

Table 2 Continued

	Intensity			Hospital Profits
	Beds per 1,000 Population	Expense per Adjusted Patient Day	Expense per Adjusted Admission	
Density	-.024 (.020)	-.005 (.029)	.066 ^a (.022)	-.125 (.312)
Service Wage	-.032 ^c (.020)	.124 ^a (.028)	.032 ^c (.022)	1.175 ^a (.320)
OTHER				
Lagged Dependent	.616 ^a (.021)	.803 ^a (.023)	.801 ^a (.021)	.318 ^a (.033)
Time	-.007 ^a (.001)	.009 ^a (.002)	.006 ^a (.001)	.075 ^a (.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

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

Table 3 Continued

	Open Heart Units/ Million	Organ Transplant Units/Million	Hospital- based Units/ Million	Total Units/ Million
OTHER				
Lagged Dependent	.543 ^a (.036)	.409 ^a (.039)	.477 ^a (.043)	.639 ^a (.038)
Time	.006 (.006)	.036 ^b (.017)	-.012 ^a (.003)	.00001 (.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, Morrissey, and Ohsfeldt (1991) found that after controlling for the fact that per capita spending was significantly different in states which adopted CON early, CON was associated with a 20.6 percent increase in hospital spending and a nine percent increase in spending on other health care. The net impact was a 13.6 percent increase in per capita spending on personal health care services. Using data derived from the annual *Hospital Statistics* on per capita hospital spending through 1990 (AHA 1977-1994) and a method that accounted for endogeneity of CON, Antel, Ohsfeldt, and Becker (1995) reported that CON had no impact on this form of spending, although they found that section 1122 reduced hospital spending. Without controlling for the endogeneity of CON, the coefficient on the CON variable was negative but very small, with a t-ratio of -.47. Taking account of endogeneity, the coefficient on CON became positive and statistically significant at the 10 percent level. It is noteworthy that explicitly accounting for CON's endogeneity made it appear to perform less well. Salkever and Bice (1976) found no impact of CON on total hospital operating costs per capita. Likewise, an earlier study by the Federal Trade Commission found that CON had no impact on hospital costs, but also found that section 1122 had a negative influence (Sherman 1988). By contrast, in our study, neither mature CON nor section 1122 had an impact on this type of expenditure, although both were associated with lower growth in acute care spending.

Table 4 Industry Organization

	For-Profit Share of Beds	HMO Market Share
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 (.039)	.879 ^a (.019)
Time	.016 (.013)	.038 (.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 an endogenous variable, had either no effect or a more negative impact on cost than when the variable was assumed to be exogenous. If the above argument held, one would have expected CON lifted to have had a more positive effect on cost when CON lifted was specified to be endogenous.

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

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

We found that mature CON reduced hospital bed supply per capita

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

Major Impact	Number of Studies Showing:		
	Decrease	No Effect	Increase
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)

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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Policy Brief

Failure of Government Central Planning Washington's Medical Certificate of Need Program

by John Barnes, Policy Analyst
January 2006

I. Introduction

Imagine your community is home to a nursing care facility that has operated for years with optimal customer satisfaction. It provides quality care and assistance, its facilities are modern and clean, and the staff is excellent. The nursing home is exceeding capacity and its operators look at the growing demand and decide to expand the facility by adding five beds. They consult their experts, study options and projections, and, after careful consideration secure a building permit and begin construction. Sounds reasonable, right? Well, they just broke the law.

Washington is one of thirty-seven states (including the District of Columbia) that require government permission to open or expand most kinds of health care facilities. In addition to the usual building permits and zoning approval, the state must grant a Certificate of Need (CON) before such facilities can be built, expanded or modified significantly. The 14 states that do not have CON laws include large states like California, Pennsylvania, and Texas, and together comprise about 35% of the U.S. population (a full list appears on page 8). [1]

Washington's Certificate of Need law applies only to providers of health care. It functions as a control valve to limit the supply of health care. Hospital and clinic managers must comply with a complicated set of established procedures and formulas to prove to state bureaucrats that there is or will be a need for whatever service they seek to provide. Without successfully navigating the CON process, it is illegal to offer new health care services to Washington residents

Federal lawmakers proposed solving a problem created by government intervention by imposing more government intervention

Public policy in Washington should focus on assuring access to affordable, high quality health care for all the people of our state. The Certificate of Need program fails to advance this fundamental goal. This study describes the history of the Certificate of Need concept, summarizes how the Washington law works, compares its stated goals with actual performance, and presents practical policy recommendations for improving access to affordable health care for the people of Washington.

II. Background

Origins of Certificate of Need

The roots of the Certificate of Need idea date back to 1964 in Rochester, New York. Local businesses and Blue Cross established a community health planning council composed of consumers, insurers and health care providers to study the need for hospital beds. The group decided there was a surplus and recommended that the state restrict supply in order to prevent what was then considered too many health care facilities. This effort culminated in New York's passage of the nation's first Certificate of Need law in 1966. [2]

Federal Certificate of Need Law

Also in 1966, Congress enacted the Comprehensive Health Planning Act. States receiving federal funds under public health and social security programs were required to establish local and state health planning agencies. Those states that already had planning agencies were required to expand the reach and authority of these departments.

In 1972 the federal government amended the Social Security Act to compel all states to review health care capital expenditures in excess of \$100,000. Failure to comply meant a state would be denied Medicare and Medicaid reimbursements for capital expenditures. [3] This provision served as the skeletal beginnings of a national Certificate of Need law. [4]

In 1974, during a time when many lawmakers were pushing for a complete government takeover of the health care system, Congress passed the National Health Planning and Resources Development Act (NHPRDA). [5]

The NHPRDA law directed each state to examine proposed health care facilities and "make findings as to the need for such services." [6] If the states did not comply with the Act's directives, the federal government would withhold funding. [7] This created strong incentives for states to implement far-reaching health care planning regulations.

The NHPRDA law recognized that "the massive infusion of Federal funds into the existing health care system" had severely distorted the health care market by "contribut[ing] to inflationary increases in the cost of health care." [8] Ironically, federal lawmakers proposed solving a problem created by government intervention by imposing more government intervention.

Distortions Created by Cost-Based Reimbursement

At that time, health care was built on a cost based reimbursement system. Price-based competition had little, if any, role in health care because providers were able to recover full cost from Medicare and Medicaid, no matter how high. The system provided little incentive for cost reduction. "There are presently inadequate incentives for the use of appropriate levels of health care," lawmakers said. [9] They believed that excess facility supply led to increased costs of business, and that those increased costs would be passed on to patients. They intended top-down health planning and strict Certificate of Need laws to constrain supply and therefore control prices.

Along with price inflation, federal lawmakers believed that a market distorted by the infusion of federal tax dollars led to poor

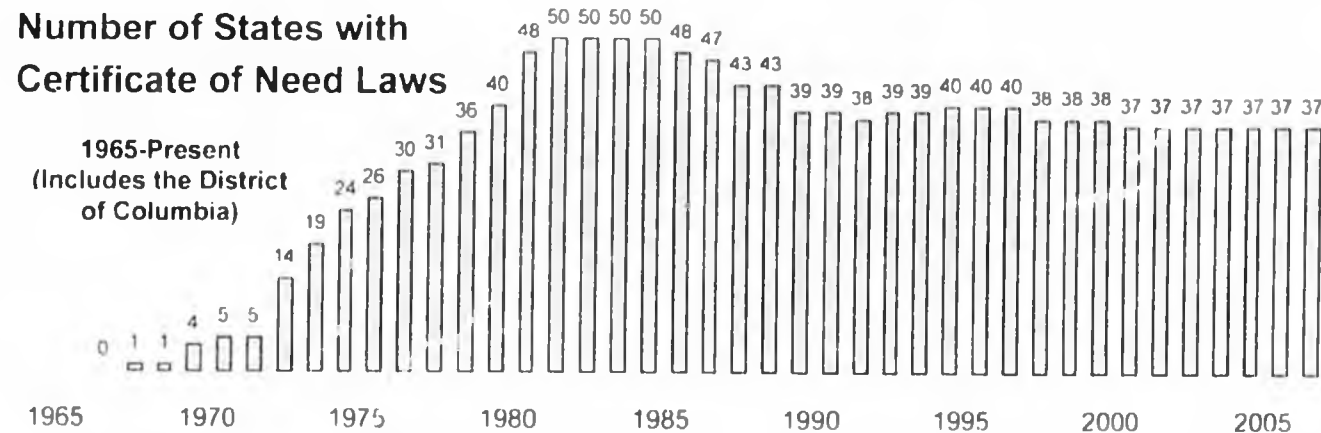
distribution of health care facilities. Thus another purpose of early health planning and Certificate of Need laws was to control the geographic distribution of health care. Lawmakers believed that "one efficient and fully-utilized piece of equipment was better than two that were under-utilized." [10]

In the years following the passage of the NHRDA, states began adopting Certificate of Need laws. The primary goal of these laws was to contain rising health care costs. Eventually every state and the District of Columbia adopted Certificate of Need regulations.

Repeal of Federal Law

In 1982, the federal government acknowledged the failure of its Certificate of Need law to reduce health care costs and repealed the mandatory health planning law. [11] In the years following federal repeal, 14 states eliminated their medical facility control laws as well. Thirty-six states and the District of Columbia retained their Certificate of Need laws. Washington is one of these. Figure 1 shows the number of states having Certificate of Need laws from 1966 to today. [12]

Figure 1



III. Overview of Washington's Certificate of Need Program

Washington imposed its first Certificate of Need requirements in 1971. [13] Later the program was changed to adapt to the requirements of the 1972 Social Security Act amendments and the 1974 NHRDA law. With these early adjustments, the program as created in the 1970s remains in force today.

The Certificate of Need program forms the backbone of centralized health planning in the state. The five stated purposes of

health planning are: [14]

- "To promote, maintain, and assure the health of all citizens in the state, to provide accessible health services, health manpower, health facilities, and other resources while controlling excessive increases in costs, and to recognize prevention as a high priority in health programs, as essential to the health, safety, and welfare of the people of the state."
- "That the development of health services and resources, including the construction, modernization, and conversion of health facilities, should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation."
- "That the development and maintenance of adequate health care information, statistics and projections of need for health facilities and services is essential to effective health planning and resources development."
- "That the development of nonregulatory approaches to health care cost containment should be considered, including the strengthening of price competition."
- "That health planning should be concerned with public health and health care financing, access, and quality, recognizing their close interrelationship and emphasizing cost control of health services, including cost-effectiveness and cost-benefit analysis."

The Certificate of Need program is administered by the state Department of Health. Between 1971 and July 2005, the state made decisions on 786 applications for Certificate of Need. Of those decisions, 177 applicants were denied permission to provide new medical services. Two Certificates of Need were rescinded after the Department's decision to grant was overturned on appeal. [15]

Washington Compared to Other States

Washington has one of the most stringent Certificate of Need laws in the country. Fourteen states have no Certificate of Need restrictions on building new medical facilities, while 36 states and the District of Columbia have such programs in place.

The scope of Certificate of Need laws varies from state to state. Some are highly detailed. In Alabama, for example, hospital managers must obtain a Certificate of Need before purchasing a new ultrasound machine. Connecticut requires state approval before a health care office can buy certain computer equipment. [16] Other states, such as Louisiana and Nebraska, apply their Certificate of Need law to only one or two types of service, leaving health care managers free to make all other decisions without the health department's prior approval.

Comparing state Certificate of Need programs is no easy task. Certain regulated medical services are more common or are more expensive than others. For example, one state might cover more medical services that are rare, like organ transplants, while another covers fewer services, such as CT scans, that are central to the health care infrastructure and affect more patients.

Figure 2 shows a comparison of Certificate of Need requirements in the fifty states and the District of Columbia. The comparison gives each state a weighted ranking, with higher numbers representing larger regulatory burdens. Under this method, Connecticut ranks the highest. Its law covers 24 services and expenditures, earning a rank of 28.8. Alaska is next highest - it covers 26 services and expenditures, but collectively these have less scope, earning a rank of 26. The last fourteen states in Figure 2 are ranked zero because they have no Certificate of Need laws.

Washington is the 18th most regulated in the country, with a weighted ranking of 12.8. Washington's Certificate of Need law covers 16 different health care services and expenditures. Washington's number 18 ranking represents a higher level of regulation than may appear at first, for two reasons. First, almost two-thirds of the states have a lower level of regulation than Washington. Second, the rating method takes into account the scope of a state's regulatory burden, in addition to its place on the list. For example, Washington ranks only six places up the list from Iowa, but its weighted level of regulation is twice as high.

Washington's Certificate of Need law covers 16 important health care services, making the state one of the most heavily regulated in the nation.

Figure 2 (Available in pdf)

IV. Description of the Project

What Washington Law Covers

As reflected by its high national ranking, Washington's Certificate of Need law is very broad. It covers every major kind of health care facility and most major health services [17] Without prior state approval, it is illegal in Washington for any person to:

- Construct, establish or develop a health care facility, including;
 - Hospitals
 - Kidney disease treatment centers (dialysis)
 - Psychiatric hospitals
 - Ambulatory surgical facilities
 - Nursing homes
 - Hospices
 - Certain continuing care retirement communities
 - Home health agencies

- Sell, purchase or lease part or all of any existing licensed hospital, regardless of profit or non-profit status;
- Increase the number of kidney dialysis treatment stations;
- Increase the number of hospital beds available to patients, or redistribute the number of existing beds among acute care, nursing home care and boarding home care;
- Make any improvement to a nursing home that exceeds two million dollars;
- Replace an existing nursing home with a new one;
- "Bank" beds at a nursing home, that is, set aside some beds to reduce the home's total number of regulated beds;
- Establish a new tertiary health service offered by a health care facility that was not offered by that health care facility within the 12-month period prior to the time the facility will offer the services. Tertiary health services include:
 - Specialty burn services
 - Intermediate care nursery
 - Neonatal intensive care
 - Transplantation of solid organs
 - Open heart surgery
 - Inpatient physical rehabilitation, Level I for persons with nonreversible multiple function impairments of moderate-to-severe complexity
 - Specialized inpatient rehabilitation services.

Washington's Certificate of Need law leaves few stones unturned. State lawmakers have placed all but a handful of medical services under the Certificate of Need umbrella. The exceptions include narrow services like air ambulance services, business computers and diagnostic imaging.

Timelines in the Process

The Certificate of Need law is costly and time consuming. It includes a number of timelines intended to serve as a chronological framework for the process. [18] In practice, however, these deadlines mean little, since they are seldom met. Figures 3 through 6 show the required timelines.

Washington's Certificate of Need law leaves few stones unturned, with all but a handful of medical services being subject to Certificate of Need requirements.

Figure 3

Number of Days	Regulatory Action
0	File a letter of intent with the Department of Health
30	File application for Certificate of Need
45	Department of Health screening period (15 working days)
90	Deadline for responding to screening questions (up to 45 days)
95	Notification of beginning of review (5 working days)
130	End of public comment period (35 days)
140	End of rebuttal period (10 days)
185	Department of Health decision date (final review period: 45 days)
Total Time for Regular Review: Approximately 6 Months	

There is also a timeline for an expedited review process. [19] If a business or organization is acquiring an existing health care facility, they fall into this category. Expedited reviews also include predevelopment expenditures and projects intended to correct deficiencies such as safety hazards or state licensing requirements. Figure 4 shows the expedited review timeline.

Figure 4

Number of Days	Regulatory Action
0	File a letter of intent with the Department of Health
30	File application for Certificate of Need
45	Department of Health screening period (15 working days)
90	Deadline for responding to screening questions (up to 45 days)
95	Notification of beginning of review (5 working days)
115	End of public comment period (20 days)
125	End of rebuttal period (10 days)
145	Department of Health decision date (final review period: 20 days)
Total Time for Expedited Review: Approximately 5 Months	

If the Department of Health denies a Certificate of Need, the applicant can ask for interim reconsideration. [20] If the Department of Health upholds its denial of a Certificate, the appeal process can begin. The first step is the Administrative Appeal, which takes the form of an adjudicative proceeding. [21] Figure 5 shows the timeline for the Administrative Appeal.

Figure 5

Time	Regulatory Action
	1. File application for adjudicative proceeding (deadline: within 30 days after Department of Health decision)
20 days	2. Administrative Law Judge* issues scheduling order and notice of hearing
4 to 5 months	3. Hearing before Administrative Law Judge
1 to 2 months	4. Post-hearing briefs submitted
1 to 2 months	5. Administrative Law Judge issues decision
Total Time for Adjudicative Proceeding: 7 to 10 Months	

* The Administrative Law Judge is an employee of the Department of Health whose role is to determine whether the Department's denial of a Certificate was made in accordance with the applicable statutes and regulations.

If the Administrative Appeal upholds the Department of Health's decision to deny a Certificate of Need, the applicant may then proceed to Judicial Review. The Judicial Review process is an appeal to Superior Court. Figure 6 shows the timeline

Figure 6

Time	Regulatory Action
	1. File Petition for Judicial Review in Superior Court (deadline: within 30 days after Administrative Law Judge decision)
6 to 10 Months	2. Trial (oral argument based on administrative record; no new evidence)
1 to 2 Months	3. Superior Court issues decision

Total Time for Judicial Appeal: 7 to 10 Months

Total Potential Time for Certificate of Need Process: 2+ Years

The Judicial Review can reverse the Department of Health's decision and issue a Certificate of Need. If that happens, then the project may begin. If the Judicial Review upholds the denial, then no Certificate of Need will be issued and the intended project cannot commence. The total potential time for the Certificate of Need Process is more than two years.

Other Factors in the CON Decision

There is much more to the process than a mere timeline. The process for acquiring a Certificate of Need depends largely on the kind of project involved. The flow chart in Figure 7 (available in pdf), at the center of this Policy Brief, shows the process required for opening a new surgery operating room.

Ambulatory surgical centers are outpatient surgery facilities that use a doctor's office environment for minor surgeries that do not require overnight stays in a hospital. These centers began appearing in the early 1970s as a way to reduce the overhead cost of conducting simple, low risk treatments. Today there are about 4,600 centers nationally, a 53% increase over the number operating just five years ago [22] The state Department of Health has developed a complicated formula for analyzing the perceived need for such centers in Washington.

The Department of Health uses numerous criteria for making this determination. At their core is a numeric formula that uses current and projected changes in population and medical capacity to calculate "net need." [23]

Other factors influence the decision as well. The Department of Health, not the marketplace, determines whether or not a proposed project is financially feasible and whether or not the project will, "foster containment of the costs of health care." [24] The Administrative Code outlines 31 criteria and sub-criteria that state managers use to decide on the need for a proposed health care facility or service [25] Those criteria include:

- " The applicant's past performance in meeting obligations under any applicable federal regulations requiring provision of charity care.
- " The existence of any civil rights complaints against the applicant.
- " The effect of the reduction, elimination, or relocation of a health service on the ability of low-income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups and the elderly to obtain needed care
- " The likelihood that all residents of the area, including low income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups and the elderly will have access to the proposed health service.

- " That the proposed project will not have an adverse effect on health professional schools and training programs.

The criteria are much the same if an applicant proposes to build a hospital. The key difference is an additional formula to calculate the number of hospital beds. Figure 8 shows this process. [26] This complicated formula, drafted in 1979 and still in use today, is based on a methodology outlined in Section 4 of the State Health Plan. Section 4 alone is over 40 pages in length.

Figure 8 (Available in pdf)

V. Review of the Effectiveness of Certificate of Need

The Certificate of Need law is intended to restrain costs and increase access to health care. The process actually has the opposite effect. By forcing anyone interested in building or expanding health care facilities to maneuver through an arcane maze of bureaucratic regulations, the state makes it harder to provide modern, flexible, community responsive health care. This section reviews the Certificate of Need program and assesses its effectiveness based on its stated goals.

The Basic Reasoning behind the CON Law Is Faulty

The chief argument proponents use to justify the Certificate of Need law is that surplus capacity in health care facilities leads to duplication of services and increased operating costs. These higher costs, they say, are then passed on to insurance companies and patients in the form of higher prices. By regulating the supply, surplus will be avoided. Health care is an "essential of life," planning advocates say, and the market is incapable of producing the necessary supply of hospital beds on its own. The reasoning behind this justification is faulty for two reasons.

First, the realities of the economy make no distinction between things deemed "essentials of life" and any other product or service. The harmful impact of over-regulation on both is the same. Health care is no different than any other product or service in our economy and the same dynamic market forces determine the quality, availability and price of it. In fact, the more essential a product or service is to meeting basic human needs, the more important it is for policymakers not to place artificial restraints on it.

Second, the "essentials of life" argument for regulating health care overlooks the even more fundamental needs of life that are bountifully provided through vigorous competition in the free market. Food, clothing, housing and transportation are vital and immediate human needs. For the vast majority of Washington residents these needs are met through a vibrant system of private buying and selling. In these cases the government's role is properly limited to protecting public safety, enforcing voluntary contracts and assisting the needy. Everyday experience shows that when the market is free to operate under minimal government oversight, the result is abundance, quality service and low price.

The more health care providers, consumers, and insurers are permitted to communicate freely in a normally-functioning marketplace, using advertising, price signals and other means, the more society will be able to provide sufficient affordable health services to meet essential human needs. The rapid growth of Health Savings Accounts and consumer-directed health plans is an indication of this trend. The Certificate of Need law works in the opposite direction, blocking fast and accurate communication between patients and health care providers, and preventing providers from responding to changing needs in the community.

Certificate of Need Laws Do Not Save Money

The assertion that Certificate of Need laws save money is further refuted by a number of recent studies. In July 2004, the Federal Trade Commission and the Department of Justice found that, "the reason that CON has been ineffective in controlling costs is that the programs do not put a stop to 'supposedly unnecessary expenditures' but merely 'redirect any such expenditures into other areas.'" [27]

In 1999, the Washington State Joint Legislative Audit and Review Committee (JLARC) reviewed the Certificate of Need law. JLARC found that the Certificate of Need law has not had any clear success in meeting its legislative goals. Its report, titled "Effects of Certificate of Need and Its Possible Repeal," reached several conclusions:

"The study found that CON has not controlled overall health care spending or hospital costs. The study found conflicting or limited evidence about the effects of CON on the quality and availability of other health care services or about the effects of repealing CON." [28]

The study went on to assess the effectiveness of the CON law in terms of cost, quality and access.

Cost:

- " The weight of the research evidence shows that CON has not restrained overall per capita health care spending. [29]
- Numerous studies have shown that CON has not controlled overall hospital spending. One study found that CON actually increased hospital expenditures.

Quality:

- " Certificate of Need concentrates volume, and the research evidence is strong that higher volumes of certain surgical procedures can lead to better outcomes. [30]
- " CON has a mixed record in concentrating volume. For example, studies show that CON was not effective in Ohio and Delaware in increasing volume, but did concentrate volume for some services in Pennsylvania. [31]

Access:

- " Washington's CON law has had no effect on improving access. [32]
- " In some instances, CON rules are used to restrict access by preventing the development of new facilities. [33]

CON Laws Do Not Increase Access

In King County there are 120 retirement communities, but only twelve are tied to nursing homes. Almost all operating nursing homes are 30 to 40 years old. [34] Waiting lists are common at even mediocre facilities. Due to Certificate of Need restrictions and other state-imposed regulations, additional nursing homes are not being added as the population ages. Under normal market conditions, the supply of elder care would increase as the need increases. The burden of the CON law disrupts this natural development.

In addition to limited access, those seeking nursing home care face high costs, even though the Certificate of Need framework is intended to reduce costs. Continuing care retirement communities tied to nursing homes require monthly payments along with large up-front fees, which can range from \$270,000 to \$400,000, and are simply beyond the reach of most people. [35] The situation indicates that the Certificate of Need law has not been effective in easing the rising burden of medical expenses for the elderly.

Studies throughout the U.S. have arrived at similar conclusions: the data indicate that a program designed to reduce cost, improve quality and promote access has not achieved any of these goals. [36] In addition, the 14 states with no Certificate of Need laws, which are home to more than one in three Americans, show no significantly higher rate of health care spending due to the lack of such laws.

Assessing Promise and Performance:

The Certificate of Need law has not met its stated goals

(All quotes are from Revised Code of Washington 70.38.015)

The crafters of Washington's health planning and Certificate of Needs law had clear goals in mind. Thirty years later, it is possible to assess the law's success or failure in meeting its goals. A clear pattern emerges. Washington's Certificate of Need process has not achieved what the authorizing law promised.

What the law promised: Health planning "should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation."

The situation today: A quick glance at the Certificate of Need procedure for surgery operating rooms (see figure 7) reveals a process that is anything but orderly. Moreover, health care providers seeking permission to build would hardly use the word "planned" to describe the process and its results. For those who must submit to it, the Certificate of Need process is expensive, inconsistent and unpredictable.

What the law promised: "The development of nonregulatory approaches to health care cost containment should be considered."

The situation today: There is far more regulation of health care today than when the CON law was enacted. State law now imposes 49 separate mandates on every health insurance policy sold in Washington. Hospitals, clinics and doctors must comply daily with stacks of complicated regulations

that inhibit the practice of medicine. Under CON, the state alone decides what health care facilities are allowed and where they will be built.

What the law promised: "Price competition should be strengthened."

The situation today: There is far less price competition in health care today than there was when the CON law passed. Patients and providers are generally unaware of health care pricing and usually have no idea how much a particular treatment costs. The CON law directly stifles price competition by discouraging existing providers from offering new services, and by blocking new competitors from entering the marketplace.

What the law promised: "Health planning should be concerned with public health care financing, access, quality emphasizing cost control of health services."

The situation today: The CON law has failed to control health care costs. In recent years the cost of health coverage has increased up to five times faster than inflation. The CON law has also failed to increase access to health care. In western Kittitas County, for example, one ambulance and one paramedic provide service for an area of some 800 square miles. [37]

Certificate of Need Suppresses Competition and Creates Monopolies

Certificate of Need appeals are a legal mechanism that health care organizations and facilities use to fend off competition. A review of the Certificate of Need action log dating from 1971 to July 2005 reveals that the issuance of a Certificate of Need is often appealed by one or more medical businesses that perceive an economic threat if a new medical facility opens in their area.

When the Department of Health granted Swedish Health Services permission to build an ambulatory surgery center in Bellevue, Overlake and Evergreen medical centers asked the Department to reconsider on the grounds that Swedish's plans would intrude upon their health planning area. The Department upheld its original decision, so Overlake and Evergreen then filed an appeal. The adjudicative hearing resulted in Swedish losing the Certificate of Need.

The Bellevue situation is not an isolated incident, this happens on a regular basis. Easy appeal is built in to the Certificate of Need process. No reasoning or criteria is required for "affected parties" to request a hearing and appeal a decision. [38] Appeals center on the cryptic minutia of the way state employees interpreted the rules, contesting, for example, the method of regression analysis, the identification of service areas, and the definitions used to determine price competition and patient choice. [39]

*The Certificate of
Need process
functions as*

The Certificate of Need process functions as protection for monopolies, insulating businesses that are already in the market and keeping competitors from entering. Anti-competitive activities that would be severely punished by federal anti-trust laws if attempted by other private companies are sanctioned

protection for monopolies, protecting businesses already in the market while keeping competitors from entering.

and promoted by the state when they involve medical providers.

Even when established health care organizations are unable to prevent competitors from entering their area, they usually succeed in using the Certificate of Need appeals system to block market entry to new providers for significant amounts of time, often years.

A 2004 study by the Federal Trade Commission and the Justice Department reported that:

"... where CON programs are intended to control health care costs, there is considerable evidence that they can actually drive up prices by fostering anticompetitive barriers to entry." [40]

The same study found that the Certificate of Need process:

"has the effect of shielding incumbent health care providers from new entrants. As a result, CON programs may actually increase health care costs, as supply is simply depressed below competitive levels." [41]

Increasingly, hospitals are facing competition from ambulatory surgery centers, which offer minor surgical procedures that do not require an overnight stay. Often times these facilities offer the same surgery as a hospital but at lower prices. It is one of the ways the market is adjusting to make health care delivery more efficient and cost effective. Established hospitals, however, use the Certificate of Need law to prevent ambulatory surgery centers from opening in their service areas, thus blocking access to health care choice and lower costs for consumers.

The 1974 national health planning law (NHPRDA) itself noted the need for incentives to develop more economical ways of treating minor surgery patients without formal admission into a hospital. Ironically, the very laws designed to foster alternatives to expensive hospital stays are today used against innovative providers who are trying to offer those very alternatives

Discouraging Public Debate

Fear of endangering their prospects for success prevents many applicants from publicly questioning or debating the process. When asked about the state refusing to issue his company a Certificate of Need, Bill Wolverton of Renal Care Group said "I'm not going to be able to speak for the record; we're about to start an appeals process." [42]

"I'm not going to be able to speak for the record; we're about to start an appeals process," remarked Bill Wolverton of Renal Care Group

Representatives of other organizations have expressed similar sentiments about applications and appeals in the pipeline. During testimony before the Senate Health and Long-Term Care Committee on a bill calling for a study of the Certificate of Need program, one expert said, "Certificate of Need applications have become much more of a political struggle than they should be." [43] Applicants are equally reluctant to appear critical of the process or departmental staff.

VI. Problems and Delays in Certificate of Need Review

The foregoing section examined the basic weaknesses in the Certificate of Need law. Research shows the law is not fulfilling its goals because the concept on which it is based, top-down limits on health services through state central planning, is fundamentally unsound. A review of the law as implemented in practice indicates the process suffers from other shortcomings as well, primarily added delays and complications in the process of gaining state approval for a project. Even if the problems discussed below were addressed, however, the foundational defects in the Certificate of Need idea would remain.

CON Process Exceeds Legal Timelines

In May 2005, the Department of Health denied permission to Swedish Medical Center and Overlake Hospital Medical Center to build new hospitals in Issaquah. This decision was the culmination of a regulatory tug-of-war that had been going on quietly since the two hospitals submitted their plans to the state more than a year before. [44] This does not include the six months Swedish and Overlake spent developing the proposal in the first place.

A review process that was supposed to provide expedited review and include public input did neither. [45] After more than a year of paperwork, lengthy meetings and countless staff hours, officials at Swedish and Overlake ended up right back where they started, and the people of Issaquah were deprived of new medical services that two respected and established hospitals were eager to provide.

Figure 9 shows the timeline for the Issaquah hospital decision process. [46] Compare this with the statutory timeline shown in Figure 3. What should have taken just over six months actually took more than thirteen months.

Figure 9

Timeline for Proposed Issaquah Hospital	
Date	Action
April 6, 2004	Letter of intent submitted
July 21, 2004	Applications submitted
July 22, 2004 - Feb. 6, 2005	Certificate of Need office's pre-review activities (application screening / public comments begin)
Feb. 7, 2005	Certificate of Need office begins review of applications
March 7, 2005	Public hearing conducted / end of public comment
March 25, 2005	Rebuttle documents submitted to Certificate of Need office
May 10, 2005	Certificate of Need office makes decision, does not issue Certificate of Need to Swedish or Overlake

Total Time for Application Process: 13 months

The Issaquah case is not a lone example. A sampling of recent Certificate of Need application timelines, shown in figure 10, reveals that the process typically takes much longer than the law says it should. In these cases, the office handling Certificate of Need requests delayed giving answers by an average of 60% beyond the time required by law.

Figure 10

Project	CON Process Should have Taken:	Actually Took:
Sale of Providence Yakima Medical Center to Health Management	5 months	8 months
Semper-Care establishing long-term acute care hospital in Spokane	6 months	9 months
Franciscan Health System establishing an ambulatory surgery center in Gig Harbor	6 months	9 months
Hospital Proposal in Gig Harbor	6 months	11 months
Average Delay		3.5 months

CON Process Takes Longer than Planned Construction

The time for securing a Certificate of Need usually exceeds the time it takes to actually build the proposed medical facility. For example, in May 2003 the state granted Swedish Health Services permission to build an ambulatory surgery center in Bellevue. The process required six months for initial planning and eight months for Certificate of Need approval.

So far, Swedish has spent three years processing Certificate of Need paperwork, for a facility that would take only 15 months to build

Swedish's competitors, Overlake and Evergreen medical centers, immediately appealed the Certificate of Need issuance. Today, more than two years after the state gave Swedish the go-ahead to begin construction, the project remains in limbo. The process dragged on so long that Swedish lost its lease option on the building it planned to convert to into the new surgery center. So far Swedish has spent three years processing Certificate of Need paperwork for a facility that, if approved, would take only fifteen months to complete. In the meantime, thousands of surgery patients who would have benefited from the new facility have been forced to go elsewhere or do without.

Community Input Is Often Ignored

Defenders of the Certificate of Need programs call it a "flexible tool" that "helps protect the critical health care infrastructure" by means of "community based planning." [47] There is no objective evidence, however, that Certificate of Need decisions

include community feedback.

The recent battle over the proposed hospital in Issaquah serves as a case in point. On March 7, 2005, the Department of Health held a public hearing in Issaquah for the community to voice its concern about Swedish and Overlake's desire to build a hospital in their area. More than five hundred people attended, many of them physicians. The real debate among participants was not whether or not there should be a hospital - only eleven people said the community did not need a new hospital - but rather who should build it, Swedish or Overlake.

The views of the vast majority of people who attended the public meeting had no effect on the final decision.

[48] As we know, the Department of Health denied both applications. The views of the vast majority of people who attended the public meeting had no effect on the final decision.

In contrast to the Issaquah case, consider what happened in Gig Harbor. Franciscan Health System proposed building a 112-bed hospital there, and in May 2004 the Department of Health announced its approval of an eighty-bed hospital. In announcing its decision, the Department of Health said, "public input overwhelmingly supported a hospital in Gig Harbor, and that public sentiment was substantiated in the fact-based analysis." [49]

Comparing what happened in Issaquah with Gig Harbor demonstrates that the public's view only matters when it agrees with the state's "fact-based analysis." Public input only seems to be relevant when it supports the pre-set designs of the planning process, and is ignored when it contradicts the regulatory formulas.

VII. Examining Arguments Made in Support of Certificate of Need

Advocates of Certificate of Need make a number of arguments to defend their views, and cite a number of states where they say it is working as intended. On closer examination, however, the evidence cited typically relies on a narrow set of data to back up these claims.

Planning proponents frequently point to studies by Ford, DaimlerChrysler and General Motors that compare health care costs in states where they have employees. For example, DaimlerChrysler says its costs ranged from \$1,331 in New York, birthplace of Certificate of Need, to \$3,519 per person in Wisconsin, which has a very limited Certificate of Need law. [50] The studies report that states with Certificate of Need laws had costs 11% to 39% lower than states without such regulations. These studies conclude that, cumulatively, all three automakers' health care costs were 30% lower in states with Certificate of Need laws. [51]

The research methods of the automakers' studies are fraught with difficulties. First, the studies only look at eight states, some with Certificate of Need laws and some without, and those states with such laws enforce them in varying degrees [52] Moreover, these states are all in the same general region, making meaningful statistical conclusions difficult.

Second, the studies fail to establish a link between Certificate of Need laws and the cost of health care benefits. Built into the report is the assumption that because the cost of health care for a certain segment of the population (auto company employees) in a few states is less than in a few other states, Certificate of Need laws that are merely intended to reduce health care costs actually do work. One condition is not necessarily related to the other, and unless a cause-and-effect relationship

can be established, the statistics are meaningless in the discussion of Certificate of Need's effectiveness.

Certificate of Need advocates use other, even less reliable, research conclusions. One oft-cited study claims that open-heart surgery mortality rates are 20% lower in states with Certificate of Need regulations than in other states. [53] A 1988 study, however, concluded the opposite of the above study; that Certificate of Need laws actually work to increase in-hospital mortality. [54]

Not long after the Federal Trade Commission and Department of Justice released their report critiquing Certificate of Need programs, the American Health Planning Association (AHPA) published a response. In it they attempt to highlight the benefits of Certificate of Need laws. Following is a point-by-point look at the AHPA's response. [55]

Claim: CON is a useful market balancing tool.

Proponents of central planning say that in an imperfect and increasingly inequitable health care system, CON regulation is a flexible tool that, when used intelligently, helps protect the critical health care infrastructure that is essential to meeting both expected and unanticipated needs.

If history has demonstrated anything, it is that the state has a poor track record when it comes to economic planning and forecasting. Yet that is exactly what the state attempts to do when it decides on the "need" for a local health care facility. Moreover, Washington's Certificate of Need program is not really "community-based," because it disregards community input that does not fit with pre-set planning formulas. The AHPA's rationale is flawed because it proposes to solve problems created by government intervention with more government intervention.

Claim: empirical evidence shows substantial economic and service quality benefit from CON regulation and related planning.

The only source cited in this claim is a Journal of the American Medical Association article arguing that open-heart surgery mortality rates are 20% lower in states with Certificate of Need regulation. This is an isolated example that attempts to link the effects of regulation with a positive statistic. The empirical connection in this single instance is weak at best.

Furthermore, numerous studies show that Certificate of Need regulation has had zero or negative impact on the quality of health service. One specialist in Walla Walla estimates that up to three people in the area die each year because a cardiac surgery center is not close enough. [56] State regulators denied a Certificate of Need to a local hospital that sought to open such a center.

Claim: CON regulation is one of the few practical planning tools available to policymakers.

The underlying premise here is that public policymakers need to be involved in health care facility planning. But do they? Bureaucrats and central economic planning inhibit private provider's ability to supply necessary services to the public at reasonable prices. Government management and the third-payer system have distorted the market, and the cost problems we see today are the results. The solution is to encourage greater consumer

control and transparent pricing informed by unimpaired market inputs.

Central planners also use a volume and quality argument to justify Certificate of Need for tertiary services such as cardiac surgery, organ transplant, etc. The argument here is that by using Certificate of Need laws to concentrate volume at specialty hospitals, the quality of services provided there will increase.

This sounds attractive in theory, but in practice the evidence supporting the argument is weak. While Washington's JLARC study concluded "the research evidence is strong that higher volumes of certain surgical procedures leads to better outcomes," it admits that this is true only for some procedures and that not all evidence supports the conclusion. [57] The same report found that Certificate of Need might reduce the quality of kidney dialysis services by reducing access. [58] This point is of more than passing importance to kidney disease sufferers, to whom reduced access to reliable dialysis can prove fatal.

CON limits are of more than passing importance to kidney disease sufferers, to whom reduced access to reliable dialysis can prove fatal.

Some health care professionals have criticized the state's rationale for concentrating volume. Dr. Robert Johnson, a cardiologist in Walla Walla, once remarked that "our knowledge about how many operations have to be done by one surgeon to have good outcomes has changed since [the state placed CON regulations for volume]. It's not nearly as many as was thought to be the case." [59]

Attempting to control the geographic distribution of health care services is another way central planning reduces patient access. The government has offered special certification for regional centers of excellence in a given field so long as those institutions perform a certain number of procedures in a year. This produces two problems. First, the requirement concentrates certain health services in one geographic area, thereby creating a hardship for people who live out of the area. The added distance increases both patient cost and risk. Second, a facility that has to perform a certain number of procedures in a year to maintain government-sanctioned preferential status may be inclined to perform unnecessary procedures simply to boost its numbers.

VIII. Policy Recommendations

Washington Policy Center's recommendations for addressing the Certificate of Need issue are presented below in priority order, beginning with the most effective and far-reaching proposal for reform. Next, two alternatives are given that would ease the regulatory burden the program places on the state's health care system.

1. Repeal the Certificate of Need Law.

Washington should follow the example of the 14 other states that have repealed their Certificate of Need laws. Disaster did not follow repeal in those states, and it will not follow repeal in Washington. The 1999 JLARC study lists repeal a key policy option. Evidence cited by Certificate of Need proponents as justifying these complex regulations is inconclusive at best, and abundant evidence to the contrary shows that Washington's Certificate of Need law likely does more harm than good. The Certificate of Need law distorts important market signals that indicate when and where new health services will be needed. More than 30 years of experience shows that the Certificate of Need law acts as an impediment to achieving cost-effective, community-responsive health care.

2. Significantly Scale Back the Certificate of Need Law.

Short of outright repeal, many states have scaled back their Certificate of Need laws so they cover only a few types of facilities or only kick in at a higher expenditure threshold. For example, CON requirements should be eliminated for nursing homes to help meet the needs of an aging population. Partial repeal could be adopted as the first step to completely phasing out Washington Certificate of Need law.

Alternatively, the legislature could enact partial repeal with the intention of leaving a limited number of health services permanently under the control of Certificate of Need regulation. In both cases, partially repeal would allow time for the legislature to review the results. Lawmakers may find the Certificate of Need law works best when it applies only to a few medical specialties, while leaving most providers free to open new clinics, hospitals and nursing homes as health needs change in the community.

3. Authorize the Certificate of Need Task Force to Investigate Thorough Reforms.

In early 2005 the legislature created a special task force to examine the Certificate of Need program. The task force began meeting later that year and is charged with making recommendations on ways to improve and update the program. Even those who support the Certificate of Need program tacitly admit it is not lowering health care costs: "We need to look at the Certificate of Need program as a health planning process in relation to escalating health care costs." [60]

Unfortunately, the task force was hamstrung from the outset. In conducting its study the task force is required to presume "that the services and facilities subject to certificate of need should continue to be subject to it." [61] Given this restriction, genuine reform is not possible. The legislature should expand the task force's authority so its members can conduct a thorough investigation of the Certificate of Need program. The task force could then assess the program's actual performance compared to stated goals, review the experiences of other states and propose practical reforms that will improve health care access for Washington residents.

IX. Conclusion - Certificate of Need Represents the Failure of Government Central Planning

Three decades of experience has supplied ample evidence that Washington's Certificate of Need program has not worked as its creators intended. The law has not controlled costs, improved quality or increased access to health care. In fact, the law has had the opposite effect, actively blocking citizens' access to health care choices and to modernized health care facilities.

CON laws actively block citizens' access to health care choices and to modernized health care facilities.

There is, however, abundant evidence the process has become arcane and politicized, and that medical organizations holding Certificates of Need use the process to keep competitors out of their area. An indication of this effect is the program's use of non-medical criteria, like an applicant's record in providing charity care or the existence of any civil rights complaints, in deciding whether to approve a Certificate of Need.

In practice, Washington's Certificate of Need law is not about improving health outcomes for citizens, it is about controlling access to health care. The state's Certificate of Need process is more important in determining how and where patients will be treated than the decisions made by doctors and hospital administrators. This point is illustrated by an observation of economist

F. A. Hayek, "The power that a millionaire, who may be my neighbor and perhaps my employer, has over me is much less than that the smallest functionary possesses who wields the coercive power of the state, and on whose discretion it depends whether and how I am able to live or work." [62]

When health care organizations are allowed to compete with each other in a system that functions more like a normal market, consumers of health care win because there are both short- and long-term incentives for providers to innovate and grow more efficient. Robust competition builds a more nimble, community-responsive and consumer-centered system that readily adapts to changing needs. Inflexible planning and regulatory structures that keep competitors out cannot achieve this.

The program's record indicates the Certificate of Need law no longer serves the public interest, if indeed it ever did. The stated purpose of the program is to foster a health care system that controls costs and meets changing conditions. Yet, to succeed such a system requires the very flexibility the Certificate of Need is designed to prevent. In a state experiencing rapid growth and demographic change, the Certificate of Need law prevents providers from adapting to the changing health needs of the community.

Three Case Studies

1. A Flawed Process

When the Department of Health decided in June 2005 that Issaquah did not need a new hospital, it did so based on the proximity of three other hospitals. "If you put a point in the center of Issaquah, there are three hospitals within 12 miles," said Laurie Jenkins, assistant secretary of health-systems quality assurance for the state Department of Health. [63] She was referring to Overlake Hospital in Bellevue, Group Health Cooperative in Redmond, and Snoqualmie Valley Hospital. A closer look, however, reveals flaws in the state's decision.

First, Group Health Cooperative is not open to the general public. Only members of the Group Health insurance network can use Group Health services. Yet the state makes little adjustment for that fact in its calculation of hospital bed availability and need.

Second, Snoqualmie Valley Hospital has what one article called "a troubled past." It is a hospital that has been plagued "by maintenance mishaps, two closures and eroded credibility." [64] But it is a hospital with twenty-eight beds, and in spite of its demonstrated unreliability, its poor reputation and many people's refusal to go there, the state included those beds when calculating bed availability and medical need.

This issue raises serious questions about the Certificate of Need determination process. Proponents of Certificate of Need planning tout the program as being "community based" or "community oriented," but in this case the process ignored two important community factors that influence the availability of hospital services to the public. An inflexible bureaucratic structure was unable to take account of legitimate local concern.

2. Stifling Competition Does Not Lower Costs

In May 2005, the Puget Sound Business Journal reported that a "statewide turf war" had erupted amongst providers of kidney dialysis, one of the many services covered by Washington's Certificate of Need law. Providers had filed more than a half dozen appeals regarding various dialysis station proposals. "I've never seen the number of appeals as high as now," one industry consultant observed. [65]

Several dialysis providers sought state permission to open new facilities or expand existing capacity. Rival companies fought Certificate of Need approvals as a way of preventing another provider from encroaching into their region. The business journal reported, "Appeals are becoming more common, as competition in the industry has surged with new market entrants." [66]

So what is the effect of hindered competition? Higher prices. "Private carriers used to pay \$200 and \$300 per treatment," remarked Palmer Pollock, a planning administrator with Northwest Kidney Centers, "now it's more than \$1,000." Instead of reducing cost, as Certificate of Need laws are intended to do, kidney dialysis prices have increased by 330% - 500%. [67] This case shows how the Certificate of Need law not only fails to constrain rising health care costs, it actually puts upward pressure on the price of certain health services.

3. Ignoring Community Input

In the 1980s, the residents of Putnam County, Georgia, ran headlong into state Certificate of Need regulators. As their federal Representative reported to Congress:

"[T]he citizens of Putnam County are proud of their 20-year-old community hospital. They built it with local funding, without using any Federal Hill-Burton funds, and they still support it locally. They are proud enough to have recently approved a 1-cent sales tax to renovate the facility. They are not seeking an expansion. The hospital has always had 50 beds, and that's what they propose to maintain.

"However, when Putnam County authorities went to the State health planning agency for the required approval under the certificate-of-need program this year, they ran into unexpected trouble. The agency looked over the request for the locally funded hospital improvements and decided to deny it - unless the hospital eliminated ten beds."

The state refused to budge and local health officials were forced to comply. Growth projections indicated that eventually all 50 beds would be needed, but the state insisted that ten of the beds be dismantled. They did so in spite of the fact that eliminating ten beds would reduce the number of nursing students the hospital could enroll, at a time when the country faced a shortage of nurses. Regulators also ignored the tremendous cost the community would incur later when hospital authority had to add back those ten beds.

This case shows how the centralized Certificate of Need process favors state-level regulators who insist on enforcing their decisions, regardless of the well-reasoned protests of local leaders.

Appendix

Description of the Certificate of Need Process for Hospital Beds

Following, in shortened form, is a description of the steps an applicant must take in requesting a Certificate of Need to build a new hospital or to add beds to an existing facility. Together, these steps represent one phase of a much larger process.

A. Develop Trend Information on Hospital Use

Steps 1 through 3: The hospital bed need determination begins with compiling historical use data—that is, how many days patients spent in hospitals based on types of treatment. (The state makes a distinction between time spent in a hospital for physical and psychiatric treatments. The need determination for psychiatric hospital beds is a separate process within the State Health Plan.)

Step 4: The state uses a ten-year history of hospital use rates to determine historical trends.

B. Calculate Bed Need Forecasts

Steps 5 and 6: Each of Washington's hospital planning area's (how the state divides the population of large areas into geographic units for planning purposes) hospital use rates are computed. At a minimum, two age blocks need to be considered: people age zero to 64 and people over 65. Age groups may be divided further.

Step 7A: The state forecasts each hospital planning area's use rates. It does this based on historical trends and projections made by the Office of Financial Management. The forecast is done for a target year, which varies. It can be as little as five or six years. [69] Moreover, the trends are arranged according to age group. Once determined, these trends are adjusted up or down, in proportion to the trend of either the statewide ten-year trend or the specific planning area's ten-year trend.

Step 7B: This is an alternative to Step 7A. In planning areas where a Health Maintenance Organization is present, adjustments must be made to factor in HMO enrollees. These adjustments are necessary because HMOs can control where their enrollees go for hospital care.

Steps 7B.1 through 7B.3: These steps serve to illustrate and correct skews created by HMO enrollment in a hospital planning area.

Steps 8 through 10: Here the bed need forecasts begin to take shape. Trend-adjusted use rates (see Steps 7A and 7B) and projected population are used to determine total forecasted patient days. Forecasted patient days are then distributed to hospital planning areas based on market share and the use of out-of-state hospitals. Average occupancy standards are then used to determine each planning area's bed need.

C. Determine Total Hospital Bed Need Forecasts

Steps 11 and 12: The non-psychiatric bed need forecasts calculated from this process are added to the psychiatric bed need forecasts (calculated in a separate process) to determine overall bed need for all hospital services. Any necessary adjustments are then made—for example, population adjustments, use rates, market

shares, and shifts in occupancy rates.

It is important to note that these processes outlined here are only part of a much larger process for building a health care facility. These regulations are above and beyond standard county and city building permits, land use requirements, Growth Management limits, environmental impact statements, zoning regulations, building codes, construction review applications and public health standards. Naturally, these additional regulations are strictest for hospitals. Other regulatory factors applied to hospitals, in addition to Certificate of Need, include the following. [70]

Additional Requirements

Licensure and Physical Plant Requirements

- " Finishes (carpet, tile, wall covering)

- " Heating and ventilation system

- " Hot water system

- " Medication handling

- " Nurse call system

- " Room size, furniture & equipment

- " Shower and toilet fixtures

Fire / Life Safety Requirements

- " Automated sprinkler system

- " Electrical generator system

- " Fire alarm system

- " Fire / life safety structural design

- " Life support system

- " Medical gas system

- " Smoke control system

Standards Adopted by State Building Code Council

- " 2003 International Building Code
- " 2003 International Fire Code
- " 2003 International Mechanical Code
- " 2003 International Plumbing Code
- " Barrier-free requirements
- " National electrical code
- " Washington state energy code
- " Washington state ventilation code

These regulations are important to protecting public health and safety, and there is no suggestion that this requirement should be loosened or repealed. The purpose here is to show that the lengthy and complicated Certificate of Need process is imposed in addition to a long list of existing requirements.

About the Author

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[1] "State and County Quickfacts," United States Census Bureau, Washington, D.C., at www.quickfacts.census.gov, accessed December 20, 2005.

[2] Citizens Research Council of Michigan, "The Michigan Certificate of Need Program," February 2005, p. 1, Lansing. See www.crcmich.org.

[3] Robert James Cimasi, "Duped by Cries of Duplication: The Failure of the Certificate of Need Regulations," April 2002, p. 1. Article accessed at the American Association of Ambulatory Surgery Centers website, www.aaasc.org on 19 December 2005.

- [4] Legislative History of the 1972 Social Security Act Amendments, federal Social Security Administration, at www.ssa.gov. The provision reads, "The Secretary may withhold or reduce reimbursement amounts to providers of services under title XVIII for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, or other expenses related to capital expenditures for plant and equipment in excess of \$100,000, which are determined to be inconsistent with State or local health facility plans." p. 3.
- [5] National Health Planning and Resources Development Act (NHPDA) of 1974, Section 2(a)(1), see Public Law 93-641.
- [6] *Ibid.*, Section 1523(a)(5).
- [7] *Ibid.*, Section 1612(b)(1).
- [8] *Ibid.*, Section 2(a).
- [9] *Ibid.*, Section 2(a)(4).
- [10] Terree Wasley, "Certificates of Need: Poor Health Care Policy," Mackinac Center for Public Policy, Mackinac, Michigan, 1993.
- [11] Michael D. Tanner, "Ending the CON Game," The Heartland Institute, Chicago, 1996.
- [12] Source of chart data is, Citizens Research Council of Michigan, "The Michigan Certificate of Need Program," February 2005, p. 3. The figures include the District of Columbia.
- [13] State of Washington, Joint Legislative Audit and Review Committee (JLARC), "Effects of Certificate of Need and Its Possible Repeal," January 8, 1999, p. 1.
- [14] Revised Code of Washington 70.38.015.
- [15] Application figures cover the period August 27, 1971 through July 7, 2005, "Certificate of Need Action Log," Office of Certificate of Need, Washington Department of Health, July 7, 2005.
- [16] Mike Norbut, "Cutting through the CONFusion: Movement to Relax the Limits," American Medical News, February 7, 2005.
- [17] Washington Administrative Code 246-310-010.
- [18] Washington Administrative Code 246-310-160.
- [19] Washington Administrative Code 246-310-150.

- [20] Washington Administrative Code 246-310-560.
- [21] Washington Administrative Code 246-310-610. The appeal timelines are governed by the Administrative Appeals Act, Revised Code of Washington 34.05.
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- [23] Washington Administrative Code 246-310-270.
- [24] Washington Administrative Code 246-310-200, Section (1).
- [25] Washington Administrative Code 246-310-210.
- [26] "Hospital Bed Need Forecasting Method," Washington State Health Plan, Volume II, Washington Department of Health.
- [27] Federal Trade Commission and Department of Justice, "Improving Health Care: A Dose of Competition," July 2004, chapter 8, p. 5. Text available at www.usdoj.gov/atr/public/health_care/204694.htm. Accessed December 20, 2005.
- [28] Washington State Joint Legislative Audit and Review Committee (JLARC), "Effects of Certificate of Need and Its Possible Repeal," January 8, 1999, p. 1.
- [29] Ibid., p. 10, based on Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?" *Journal of Health Politics, Policy, and Law*, Volume 23, No. 3, June 1998; Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993; Delaware Health Care Commission, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume I, Final Report, May 1996; Arnold, Judith and Daniel Mendelson, (Lewin ICF) "Evaluation of the Pennsylvania Certificate of Need Program," submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992; Custer, William S., Ph.D., "Certificate of Need Regulation and the Health Care Delivery System," Center for Risk Management and Insurance Research, Georgia State University, February 1997.
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- [32] Ibid., p. 6. "Key Informants: the Health Policy Analysis Program conducted interviews with ten experts chosen for their

knowledge of the state's CON program and the overall health policy environment in Washington state. Informants were chosen to represent consumer, business, labor, academic, and government perspectives."

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[34] Liz Taylor, "How the state messed up your choices in nursing homes, retirement communities," *The Seattle Times*, November 15, 2004.

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[37] Peter Neurath, "Help on the way?", *Puget Sound Business Journal*, October 28 - November 3, 2005, pp. 31-32.

[38] Washington Administrative Code 246-310-180.

[39] For a case description, see "High-stakes turf war erupts over kidney dialysis," by Peter Neurath, *Puget Sound Business Journal*, April 29 - May 5, 2005.

[40] "Improving Health Care: A Dose of Competition," Federal Trade Commission and the Department of Justice, Washington, D.C., July 2004, chapter 8, p. 2.

[41] Ibid.

[42] Peter Neurath, "High-stakes turf war erupts over kidney dialysis," *Puget Sound Business Journal*, April 29 - May 5, 2005.

[43] Testimony given in support of the bill before the Senate Health and Long Term Care Committee, March 28, 2005, Bill Report for Engrossed Second Substitute House Bill 1688, Washington State Legislature, at www.leg.wa.gov.

[44] Sonia Krishman, "Issaquah hospital considered unnecessary," *The Seattle Times*, May 11, 2005.

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[46] Issaquah hospital timeline obtained from the Certificate of Need office, July 7, 2005.

[47] "The Federal Trade Commission and Certificate of Need Regulation: An AHPA Critique," American Health Planning Association, January 2005, p. 14-15, at www.ahpanet.org, accessed November 5, 2005.

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[51] *Ibid.*

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[54] Michael A. Morrissey, "Certificate of Need, Any Willing Provider and Health Care Markets," Lister Hill Center for Health Policy, University of Alabama at Birmingham, 1988-89.

[55] See "The Federal Trade Commission and Certificate of Need Regulation: An AHPA Critique," *American Health Planning Association*, January 2005.

[56] Kathleen Obenland, "St. Mary wants to be able to offer heart surgeries," *Walla Walla Union-Bulletin*, November 16, 1999, quoting Dr. Robert Arnold Johnson, cardiologist with the St. Mary Physician Group.

[57] Washington State Joint Legislative Audit and Review Committee (JLARC), "Effects of Certificate of Need and Its Possible Repeal," January 8, 1999, p. 15.

[58] *Ibid.*, p. 16.

[59] Kathleen Obenland, "St. Mary wants to be able to offer heart surgeries," *Walla Walla Union-Bulletin*, November 16, 1999, quoting Dr. Robert Arnold Johnson, cardiologist with the St. Mary Physician Group.

[60] Testimony given in support of the bill before the Senate Health and Long-Term Care Committee, Bill Report for Engrossed Second Substitute House Bill 1688, Washington State Legislature, March 28, 2005. See www.leg.wa.gov.

[61] Bill report on Engrossed Second Substitute House Bill 1688 "Creating a task force to review the certificate of need program and the health care facilities bonding program," enacted May 4, 2005, Washington State Legislature at www.leg.wa.gov.

[62] F.A. Hayek, "Law, Legislation and Liberty," University of Chicago Press, Chicago, 1947.

[63] Sonia Krishman, "Issaquah hospital considered unnecessary," The Seattle Times, May 11, 2005.

[64] Ibid.

[65] Peter Neurath, "High-stakes turf war erupts over kidney dialysis," Puget Sound Business Journal, April 29 - May 5, 2005.

[66] Ibid.

[67] Ibid.

[68] Patrick John McGinley, "Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a Managed Competition System," Florida State University Law Review (1995).

[69] In the recent unsuccessful Certificate of Need process undertaken by Swedish and Overlake hospitals to build a hospital in Issaquah, both companies were required to forecast need out to the year 2018

[70] Washington State Department of Health, Facilities and Services Licensing, Construction Review Services, at www.doh.wa.gov.

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Alaska State Legislature

Chairman

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Member

Labor and Commerce Committee

State Affairs Committee

Economic Development, Trade & Tourism
Committee

Education Committee

Joint Armed Services Committee

Finance Subcommittees

Labor & Workforce Development

Community & Economic Development

Military & Veterans' Affairs



A Communication From

REPRESENTATIVE BOB LYNN

District 31 Anchorage

E-Mail: Representative_Bob_Lynn@legis.state.ak.us

"Bob Lynn's Alaska Blog" AlaskaDistrict31.blogspot.com

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Juneau, AK 99801-1182

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February 13, 2005

Ms. Karleen Jackson, Commissioner
State of Alaska
Department of Health and Social Services
P.O. Box 110601
Juneau, Alaska 99811-0601

Dear Commissioner Jackson,

This letter is to request a meeting with you and your Director of Administrative Services, Janet Clarke. My bill, HB 287 addresses Certificate of Need (CON) issues. Your Department recently submitted your cost scenarios of \$41 Million Dollars to the Lieutenant Governor's office for inclusion on the signature gathering petitions on the same (CON) subject. These figures will likely be similar to HB 287. The primary difference between HB 287 and the Initiative is that HB 287 retains the CON for communities of less than 25,000 in population. The Initiative, on the other hand, would eliminate the CON throughout Alaska regardless of the population.

Obviously, a \$41 Million fiscal note will severely impact my bill and this has me very concerned. The co-sponsors of my bill, Representatives Cognill, Chenault and Kohring share the same concerns. We need to understand how your office arrived at \$41 million, how it was derived, and that the fiscal note be as accurate as possible.

We would appreciate a written response to the following questions.

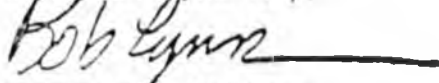
1. It is our understanding that independent facilities receive a flat rate for medical procedures under Medicaid and that hospitals receive additional facility and operational fees for the same procedures. Please identify for us the difference that you would pay to an independent facility and a hospital under Medicaid including all the additional fees paid to a hospital.
2. Of the facilities you have estimated would be built if CON were eliminated, how many of them would be considered to be independent facilities and how many would be considered hospitals eligible for the additional payments?

3. If these facilities are not eligible for the additional construction or operational payments, it would seem that there would actually be a reduction in costs to Medicaid since the number of Medicaid patients would remain the same regardless of the number of facilities. Please explain this.
4. What criteria were used to estimate the additional facilities? Were they considered to be necessary services not currently provided by other providers or were they facilities that have actually been proposed for development?
5. What criteria were used to estimate the number of beds in these facilities? They seem excessively large compared to other such facilities in much larger markets in the United States. For instance, the orthopedic hospital referenced in the note at 30 beds would compare to the orthopedic hospital in Houston, Texas at 48 beds, which serves a client base of 5 million people. The cardiac hospital also seems to be very large and as regards the 90-bed psychiatric hospital in Fairbanks, we are unaware of the level of psychiatric problems in the Fairbanks area that would justify 90 hospital beds.

After receiving your written answers to these questions, we would appreciate a meeting with you to discuss this issue. Nancy Manly, my Chief-of-Staff, will be able to coordinate our schedules to facilitate a meeting. I understand that OMB is also involved in this fiscal note issue. It may be useful to have an OMB representative there that could provide some independent evaluation, as well as someone from the Lt. Governor's office who will have to eventually issue the petition booklets.

Please let us know your intentions on these matters.

Thank you for your help,



Representative Bob Lynn

cc: Lt. Governor Loren Leman
Cheryl Frasca, OMB
Representative Coghill
Representative Chenault
Representative Kohring

STATE OF ALASKA

FRANK H. MURKOWSKI, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

PO BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE (907) 465-3030
FAX (907) 465-3068

March 1, 2006

Honorable Bob Lynn
Alaska House of Representatives
State Capitol, Room 415
Juneau, AK 99801-1182

Dear Representative Lynn,

I apologize for the delay in responding to your questions related to the certificate of need (CON) program included in your letter to me of February 13, 2006. The questions and responses follow:

Question 1: It is our understanding that independent facilities receive a flat rate for medical procedures under Medicaid and that hospitals receive additional facility and operation fees for the same procedures. Please identify for us the differences that you would pay to an independent facility and a hospital under Medicaid including all the additional fees paid to a hospital

Response: Medicaid pays for Ambulatory Surgical Center services through an all inclusive rate for the service provided. The payment rates are based on an Alaska adjusted, national Medicare rate. The rate is annually adjusted for inflation.

Medicaid outpatient hospital payment rates are established using a significantly different methodology. Outpatient rates are based on a percentage of allowable charges derived from cost reports provided to the State by the facility.

When a certificate of need is approved and the hospital opens a newly approved inpatient project, the payment rate is adjusted, to include the allowable capital costs of the new project. We assume this increase is the additional fees amount referred to in your question.

Outpatient hospital rates are also adjusted for new CON approved costs when certificate of need project costs and charges become part of an outpatient hospital's cost basis for rate setting.

Question 2: Of the facilities you have estimated would be built if CON were eliminated, how many of them would be considered to be independent facilities and how many would be considered hospitals eligible for the additional payments?

Response: We assume you are asking which projects would fall under the facility rate setting methodology as opposed to those who would be paid an all inclusive rate for the services provided as described in our response to question #1 (above). Health care facilities subject to the facility rate setting methodology are hospitals (general acute care, acute psychiatric, and long-term acute), skilled nursing facilities/intermediate care facilities (nursing facilities), and rural health clinics. Some of the projects included in the department's cost estimates for the proposed initiative may be independent facilities OR may be subject to formal facility rate setting—depending where the project is located. For example, an outpatient surgery suite built as an addition to an existing acute care hospital would be subject to a different payment methodology than an ambulatory surgery center built and licensed as a stand-alone facility.

Question 3: If these facilities are not eligible for the additional construction or operational payments, it would seem that there would actually be a reduction in costs to Medicaid since the number of Medicaid patients would remain the same regardless of the number of facilities. Please explain this.

Response: Independent facility payment rates include necessary capital and operations costs while hospital payment rates are facility specific and do not include necessary capital costs until the certificate of need adjustment takes place. Capital rate adjustments alone would not appear to generate a cost to the system beyond what would be reasonable. Over the long term the hospital rate adjustments makes the in-patient and out patient hospital rates comparable and does not necessarily drive Medicaid costs up or down.

Question 4: What criteria were used to estimate the additional facilities? Were they considered to be necessary services not currently provided by other providers or were they facilities that have been proposed for development?

Response: The estimates prepared were based on materials and information received by department staff including prior letters of intent, inquiries, prior certificate of need applications, and knowledge of recent trends in other states. The projects are representative of health care facilities that would likely be pursued by private developers in the future; but should not be regarded as a definitive list. The department is not suggesting that a need could be demonstrated for any particular project (this could only be determined if a certificate of need application was submitted and the appropriate analysis conducted). Rather, based on the best information available, the department is suggesting that these projects are representative of what would likely be pursued should the proposed initiative become law.

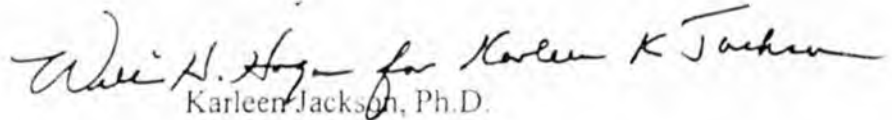
Question 5: What criteria were used to estimate the number of beds in these facilities? They seem excessively large compared to other such facilities in much larger markets in

the United States For instance, the orthopedic hospital referenced in the note at 30 beds would compare to the orthopedic hospital in Houston, Texas at 48 beds, which serves a client base of 5 million people. The cardiac hospital also seems to be very large and as regards the 90-bed psychiatric hospital in Fairbanks, we are unaware of the level of psychiatric problems in the Fairbanks area that would justify 90 hospital beds

Response: See response to # 4 above

Finally, please recognize that House Bill 287 as introduced is significantly different than the proposed certificate of need initiative. House Bill 287 eliminates certificate of need requirements for nursing facilities and residential psychiatric treatment centers in much of the state. This would likely result in significant additional costs to the department insofar as both of these facility types are supported largely by Medicaid. A fiscal note for House Bill 287 will be forthcoming shortly.

Sincerely,


Karleen Jackson, Ph.D.
Commissioner

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

PO BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE (907) 465-3030
FAX (907) 465-3068

March 13, 2006

The Honorable Bob Lynn
Representative District 31
State Capitol, Room 415
Juneau, Alaska 99811

The Honorable Mike Chenault
Representative District 34
State Capitol, Room 505
Juneau, Alaska 99811

Dear Representative's Lynn and Chenault:

The following information is provided in response to our meeting of March 1, 2006 and your subsequent letter of March 2, 2006 related to HB 287 and the Certificate of Need (CON) program.

- Per request of both Representatives, please provide a revised fiscal analysis with a CS for HB 287; explain in detail how the fiscal analysis is derived.

Outlined below is a summary of the impact to the Medicaid program of HB 287 based on the revised committee substitute. Please note, one of the costliest items in the fiscal note is the inpatient psychiatric beds, where Medicaid is a primary payor. Details of the fiscal analysis is provided on ATTACHMENT #1, where we have provided Draft fiscal notes.

CS HB 287

Limiting CON for facilities (other than NH & RPTC) to areas with population of 25,000+

Summary of Fiscal Notes

All Medicaid Components

	State Fiscal Year					
	2007	2008	2009	2010	2011	2012
Total	\$2,373.5	\$4,747.0	\$7,142.4	\$14,546.6	\$16,195.1	\$45,667.2
Federal	\$1,366.6	\$2,733.3	\$3,602.6	\$7,273.3	\$8,097.6	\$22,833.6
GF Match	\$1,006.8	\$2,013.7	\$3,539.8	\$7,273.3	\$8,097.6	\$22,833.6

- *Please provide a history of CON applications for the last ten years to see what historical has occurred with the CON program as a basis for what could happen in the future.*

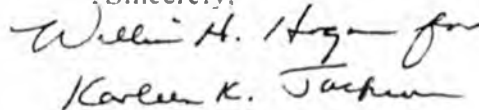
Please see ATTACHMENT #2

- *Please provide a theoretical example of what Medicaid would pay based on cost associated with Outpatient Hospital treatment vs. Ambulatory Surgical Center.*

Please see ATTACHMENT #3 with two different examples; the first is "Treatment for Fractured Arm" and the second is for "Cat Scan of Abdomen".

If you have questions concerning this information, please feel free to contact either Tony Lombardo at 465-3030 or Janet Clarke at 465-1630.

Sincerely,



Karleen K. Jackson, Ph.D
Commissioner

Attachments 1-3

Cc: Deputy Commissioner Lombardo
Assistant Commissioner Clarke
Sherry Hill, Special Assistant
Elmer Lindstrom, Special Assistant
Dave Pierce, CON Program

Return

DRAFT

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number _____

Bill Version: CS HB287 (HES)

() Publish Date _____

Revision Date/Time (Note if correction) _____

Dept. Affected Health & Social Services

Title LIMIT CERTIFICATE OF NEED TO BOROUGHES
WITH A POPULATION OF LESS THAN 25,000

RDU Behavioral Health

Component Behavioral Hlth Medicaid Svcs

Sponsor LYNN

Requester HOUSE (HES)

Component No 2660

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						26,724.4
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	26,724.4

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

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

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						13,362.2
1003 GF Match						13,362.2
1004 GF						
1037 GF Mental Health						
Other (Specify Type-do not abbreviate)						
Other (Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	26,724.4

Estimate of any current year (FY2006) cost: _____

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

CS HB287 amends the certificate of need (CON) by exempting certain health facilities in the most populated areas from the program. The current CON program applies to all areas of the state (AS 18.07). This bill would apply CON only to health facilities (other than nursing homes and residential psychiatric treatment centers) in the less populated areas of the state: (a) boroughs with a population of less than 25,000, (b) the unorganized borough, and (c) communities with a critical access hospital.

Continued

Prepared by Janet Clarke, Assistant Commissioner

Phone _____

Division Finance & Mgmt Services

Date/Time 03/08/2006

Approved by _____

Date 03/13/2006

ANALYSIS CONTINUATION

Alaska law requires that a person who plans to undertake certain activities related to a health care facility or to convert a facility to a nursing home must first demonstrate a need for the proposed service and obtain a certificate of need from the Department.

The CON program applies to these health care facilities: private, municipal, state or federal hospital, psychiatric hospital, skilled nursing facility, residential psychiatric treatment center, independent diagnostic testing facility, tuberculosis hospital, kidney disease treatment center, intermediate care facility, and ambulatory surgical facility. Excluded are the Alaska Pioneer's Home and Alaska Veteran's Home and the offices of private physicians or dentists.

This bill would exempt facilities other than nursing homes and RPTCs in locations with population at or above 25,000 from the certificate of need requirement. It would eliminate the review of approximately 90%-95% of all certificates of need for the remaining health care facilities as almost all facilities are located in the exempt areas. Of the facilities currently subject to CON, 12 of the 25 hospitals/co-located nursing facilities, and all of the 9 ambulatory surgical centers, 3 independent diagnostic testing facilities, 4 kidney dialysis centers, would be exempt under CS HB287. All of the 4 freestanding nursing facilities and 4 residential psychiatric treatment centers would still be subject to CON.

CS HB 287 would affect the 5 boroughs with population greater than 25,000: Municipality of Anchorage, Matanuska-Susitna Borough, Fairbanks North Star Borough, City and Borough of Juneau, and Kenai Peninsula Borough. Health care facilities and nursing home beds in these boroughs would not be subject to the CON process. Within the Kenai Borough, the community of Seward has a critical access hospital meaning that Seward is still covered by the CON program, but all other areas in the borough are not. Since the remainder of the state is either in a borough with a population less than 25,000 or is part of the unorganized borough the CON program would still be required in all other locations.

Based on interest expressed by health care providers and national trends the Department estimates that there are many projects in the exempt areas that would potentially start development immediately after the bill was passed. It is anticipated that construction on these facilities would peak within 3 years and that most, but not all, of the construction would be completed within 5 years.

In the Behavioral Health Medicaid component, the projects described below might be built if certain health facilities in the 5 largest boroughs are exempt from the CON program

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Note that Residential Psychiatric Treatment Centers are not exempt under CS HB 287.

The fiscal note is based on a list of potential projects. It is not possible to identify with any confidence which projects would or would not have been approved anyway, although we know that some would. The department's best estimate is that approximately 30% of the projects would have successfully completed the CON process. **The fiscal note represents the aggregate Medicaid costs for the 70% of potential projects affected by CS HB 287 that likely would not have received a CON.**

The uncertainty stems from several reasons: some projects are for new services that we do not have experience with yet; the standards for CON were recently changed and we do not have enough experience yet to speculate; some projects would not submit an application because the provider was aware that they were unlikely to receive the CON.

Alcohol and Drug Hospital: A couple of years ago a 30-bed facility in Anchorage was discussed with Department staff. The cost is based on similar type of facilities and would be about the same as an RPTC facility except without all of the educational and gym facilities. This specialty hospital would be licensed as a psychiatric hospital but serve alcohol and drug clients. *Estimated annual cost to Medicaid \$16,607.5 starting in FY2012.*

Psych Hospital Beds: Valley Hospital has an empty 40-bed acute care facility that they are looking to sell or lease. They have contacted the Department on at least 3 occasions regarding the conversion of the facility to a psych hospital. If Fairbanks became a regional center and CON was not required, 40-60 beds would likely be built, primarily for adolescents and children. Last year North Star submitted a CON proposing development of 30 inpatient psychiatric hospital beds for children in Fairbanks. They would likely have planned for more if it were not for CON. In addition, Providence had plans up until recently to build a 60-bed psych facility in Anchorage. Although this facility will not be built, someone else might consider building a facility of that size. The costs per bed were estimated from recent CON applications. *Estimated annual cost to Medicaid \$10,116.9 starting in FY2012 for a total of 90 beds*

The GF match is based on the statutory SFY average FMAP for Title XIX for the appropriate year (2007-2008=57.58%; 2009=50.44%; 2010-2012=50.00%)

Return

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: CS HB287 (HES)
() Publish Date _____
Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction): _____
Title: LIMIT CERTIFICATE OF NEED TO BOROUGHES WITH A POPULATION OF LESS THAN 25,000

RDU: Health Care Services
Component: Medical Services

Sponsor: LYNN
Requester: HOUSE (HES)

Component No: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	2,373.5	4,747.0	7,142.4	14,546.6	16,195.1	18,942.7
Miscellaneous						
TOTAL OPERATING	2,373.5	4,747.0	7,142.4	14,546.6	16,195.1	18,942.7

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

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

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	1,366.7	2,733.3	3,602.6	7,273.3	8,097.6	9,471.4
1003 GF Match	1,006.8	2,013.7	3,539.8	7,273.3	8,097.5	9,471.3
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	2,373.5	4,747.0	7,142.4	14,546.6	16,195.1	18,942.7

Estimate of any current year (FY2006) cost: _____
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

CS HB287 amends the certificate of need (CON) by exempting certain health facilities in the most populated areas from the program. The current CON program applies to all areas of the state (AS 18.07). This bill would apply CON only to health facilities (other than nursing homes and residential psychiatric treatment centers) in the less populated areas of the state: (a) boroughs with a population of less than 25,000, (b) the unorganized borough, and (c) communities with a critical access hospital.

Continued

Prepared by: Janet Clarke, Assistant Commissioner
Division: Finance & Management Services
Approved by: _____
Agency: Department of Health and Social Services

Phone: _____
Date/Time: 03/10/2006
Date: 03/13/2006

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Alaska law requires that a person who plans to undertake certain activities related to a health care facility or to convert a facility to a nursing home must first demonstrate a need for the proposed service and obtain a certificate of need from the Department.

The CON program applies to these health care facilities: private, municipal, state or federal hospital, psychiatric hospital, skilled nursing facility, residential psychiatric treatment center, independent diagnostic testing facility, tuberculosis hospital, kidney disease treatment center, intermediate care facility, and ambulatory surgical facility. Excluded are the Alaska Pioneer's Home and Alaska Veteran's Home and the offices of private physicians or dentists.

This bill would exempt facilities other than nursing homes and RPTCs in locations with population at or above 25,000 from the certificate of need requirement. It would eliminate the review of approximately 90%-95% of all certificates of need for the remaining health care facilities as almost all facilities are located in the exempt areas. Of the facilities currently subject to CON, 12 of the 25 hospitals/co-located nursing facilities, and all of the 9 ambulatory surgical centers, 3 independent diagnostic testing facilities, 4 kidney dialysis centers, would be exempt under HB287. All of the 4 freestanding nursing facilities and 4 residential psychiatric treatment centers would still be subject to CON.

CS HB 287 would affect the 5 boroughs with population greater than 25,000: Municipality of Anchorage, Matanuska-Susitna Borough, Fairbanks North Star Borough, City and Borough of Juneau, and Kenai Peninsula Borough. Health care facilities and nursing home beds in these boroughs would not be subject to the CON process. Within the Kenai Borough, the community of Seward has a critical access hospital meaning that Seward is still covered by the CON program, but all other areas in the borough are not. Since the remainder of the state is either in a borough with a population less than 25,000 or is part of the unorganized borough the CON program would still be required in all other locations.

Based on interest expressed by health care providers and national trends the Department estimates that there are many projects in the exempt areas that would potentially start development immediately after the bill was passed. It is anticipated that construction on these facilities would peak within 3 years and that most, but not all, of the construction would be completed within 5 years.

In the Health Care Services Medicaid component, the projects described below might be built if certain health facilities in the 5 largest boroughs are exempt from the CON program

FISCAL NOTE
FN #

STATE OF ALASKA
2006 LEGISLATIVE SESSION

BILL NO.CS HB287 (HES)

ANALYSIS CONTINUATION

The fiscal note is based on a list of potential projects. It is not possible to identify with any confidence which projects would or would not have been approved anyway, although we know that some would. The department's best estimate is that approximately 30% of the projects would have successfully completed the CON process. **The fiscal note represents the aggregate Medicaid costs for the 70% of potential projects affected by CS HB 287 that likely would not have received a CON.** The cost estimates are conservative because, while all will have additional costs for Medicaid, for some of the facility types we were unable to quantify the cost.

The uncertainty stems from several reasons: some projects are for new services that we do not have experience with yet; the standards for CON were recently changed and we do not have enough experience yet to speculate; some projects would not submit an application because the provider was aware that they were unlikely to receive the CON.

Ambulatory Surgery Centers: Based on letters of intent, prior CONs that were denied or withdrawn, or requests for information for surgery suites in a location. The cost is an average of recent surgery projects that submitted certificate of need applications. *Estimated annual cost to Medicaid: \$2,196.7 with 12 beds added in FY2007 and another 14 beds in FY2008 and FY2009, for a total of 40 beds*

Cardiac Hospital: Although the Department has not received any specific inquiries for this type of service it is growing around the country and interest in Alaska may not be too far off. The cost was estimated based on an average cost of acute hospital beds in recent CON applications. *Estimated annual cost to Medicaid: \$2,747.6 with 30 beds starting in FY2010*

Cardiac Cath Labs: Four Labs are expected in the next 3 years. Fairbanks Memorial Hospital is considering one or two Labs now. It is expected that competition for labs in Anchorage and the Mat-Su Valley would develop and that Soldotna will want the service also. *Estimated annual cost to Medicaid is unknown*

Independent Diagnostic and Testing Facilities: Additional competition would be expected in this area with 7 new facilities starting up in Juneau, Soldotna, Fairbanks, Mat-Su and Anchorage. Information received indicates Alaska Open Imaging has considered opening in Juneau and Providence Imaging in Wasilla. These projects would likely all be built in 1-2 years. *Estimated annual cost to Medicaid is unknown*

FISCAL NOTE

FN #

STATE OF ALASKA

BILL NO.CS HB287 (HES)

2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

General Acute Care Hospital: Providence has indicated a need for 50-100 beds and Valley Hospital has a partially completed space for 75 beds. Soldotna and Fairbanks would be expected to add beds as well. The costs were estimated based on recent certificate of need applications. *Estimated annual cost to Medicaid: \$8,242.8 for 200 beds, with 40 new beds added in each of the next 5 years.*

Kidney Dialysis Centers: One new 16-station facility may be developed in Anchorage. We did have one contact requesting information on certificate of need for such a facility. *Estimated annual cost to Medicaid is unknown. Probably not started until FY2010.*

Long Term Acute Care Hospital Beds: This is a new service that was approved for Anchorage in 2005. There may be an interest in developing these same services in Fairbanks and the Mat-Su Valley. Long Term Acute Care hospitals are specialty hospitals, without emergency rooms or outpatient services, designed to provide extended medical and rehabilitative care for critically ill, medically complex patients who have multiple acute or chronic conditions. Most patients in these facilities are age 65 and over. Their length of stay is too long for acute care, but their medical condition is not right for long-term care, plus they have an opportunity for rehabilitation. These services will be paid for primarily through Medicare and Medicaid. *Estimated annual cost to Medicaid: \$3,008.0 for 90 total beds starting in FY2010.*

Radiotherapy: Three programs are expected. Inquiries have been made for this type of facility in Wasilla and Fairbanks and a letter of intent for expansion was received a couple of years ago for expansion of radiotherapy in Anchorage. *Estimated annual cost to Medicaid is unknown. Probably not started until FY2010.*

PET/CT Scanner: Fairbanks has indicated a continuing interest in this service even though a project was denied recently. A new one might be added in Anchorage. *Estimated annual cost to Medicaid is unknown. Probably started in FY2007.*

Orthopedic Hospital: Although none exists in Alaska, these specialty hospitals are growing rapidly in the rest of the US. It is only a matter of time before they move to Alaska. Costs were estimated to be similar to Cardiac Hospitals. *Estimated annual cost to Medicaid: \$2,747.6 for 30 beds starting in FY2012.*

The GF match is based on the statutory SFY average FMAP for Title XIX for the appropriate year (2007-2008=57.58%; 2009=50.44%; 2010-2012=50.00%).

Certificate of Need Applications 1996-2005

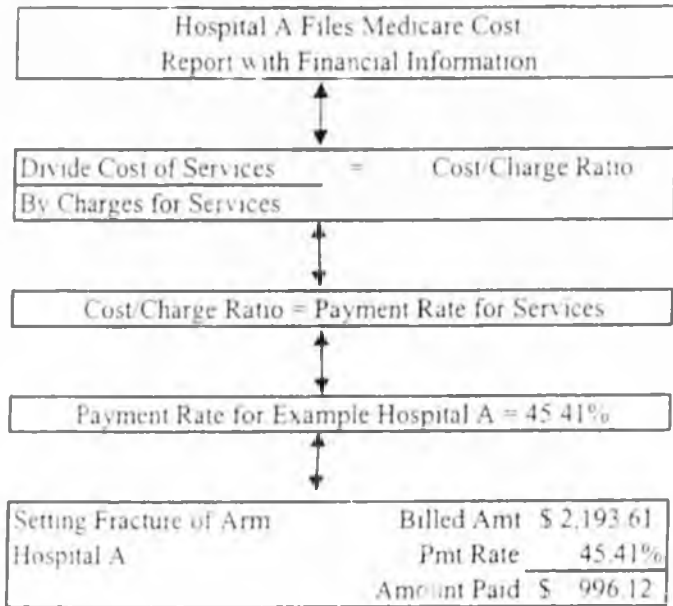
Year	Applicant	Location	Activity	Cost	Decision
2005	Fairbanks Memorial Hospital	Fairbanks	Emergency Dept Expansion	\$ 33,202,843	Approved
2005	Boys & Girls Home & Family Svcs	Fairbanks	60 RPTC Beds	\$ 14,750,000	Denied - did not meet Standards
2005	North Star Behavioral	Fairbanks	30 Psych & 30 RPTC Beds	\$ 10,200,000	Denied - did not meet Standards
2005	PAMC/APCA Joint Venture	Anchorage	6-suite Ambulatory Surgery Ctr	\$ 6,500,000	Denied - did not meet need Std.
2005	Doctors Surgery Center	Anchorage	2-suite Ambulatory Surgery Ctr	\$ 8,000,000	Withdrawn
2005	ARH/AK Spine Institute	Anchorage	3-suite Ambulatory Surgery Ctr	\$ 12,418,406	Withdrawn
2005	PAMC/PCC Joint Venture	Anchorage	60-bed Long-Term Hosp (LTACH)	\$ 21,200,000	Approved
2005	North Star Behavioral	Anchorage	60-bed RPTC	\$ 10,015,000	Approved
2005	Cornell Corporation	Anchorage	60-bed RPTC	\$ 6,350,000	Withdrawn
2004	Providence (PAMC)	Anchorage	Open-Architecture MRI	\$ 3,200,000	Approved
2004	Central Peninsula Hospital	Soldotna	Replacement Facility/Expansion	\$ 49,611,816	Approved
2004	Fairbanks Memorial Hospital	Fairbanks	Outpatient Radiology Expansion	\$ 36,069,090	Approved
2004	Ketchikan General Hospital	Ketchikan	Remodel of Long-Term Care	\$ 4,012,631	Approved
2003	Providence AK Medical Ctr.	Anchorage	Linear Accelerator	\$ 1,750,000	Approved
2003	Providence AK Medical Ctr.	Anchorage	CT Scanner	\$ 1,120,000	Approved
2003	Valley Hospital - Palmer	Mat-Su Valley	76-bed Replacement Hospital	\$ 87,800,000	Approved
2003	Providence AK Medical Ctr	Anchorage	Modification of the 2002 CON	\$ 25,300,000	Approved/Withdrawn later
2003	Renal Care Group	Anchorage	Replacement Dialysis Center	\$ 6,267,000	Approved
2003	Renal Care Group	Wasilla	Kidney Dialysis Center	\$ 1,258,085	Approved
2003	Wildflower Court	Juneau	Add 5 LTC Beds	\$ 863,550	Approved
2003	Providence AK Medical Ctr.	Anchorage	19-bed ICU Expansion	\$ 11,300,000	Approved
2002	Providence AK Medical Ctr.	Anchorage	60-bed Psych Hospital	\$ 21,000,000	Approved
2002	Wildflower Court	Juneau	Convert 11 Asst Liv Beds to LTC	\$ 100,000	Denied
2002	Fairbanks Memorial Hospital	Fairbanks	Expand Clinical Laboratory	\$ 12,900,000	Approved
2002	Alaska Psychiatric Institute	Anchorage	80-bed Replacement Hosp.	\$ 41,744,000	Approved
2002	Renal Care Group	Fairbanks	Kidney Dialysis Center	\$ 1,754,100	Approved
2002	Valdez Community Hospital	Valdez	21-bed Replacement Hosp.	\$ 24,100,000	Approved
2002	Sitka Community Hospital	Sitka	Conversion of 5 beds to LTC	\$ 30,000	Approved
2002	Providence AK Medical Ctr.	Anchorage	Mod. Of N. Tower/Lab Expand	\$ 8,555,000	Approved
2001	Ketchikan General Hospital	Ketchikan	MRI Acquisition & Construction	\$ 1,182,720	Approved
2001	Sitka Community Hospital	Sitka	Conversion of 5 beds to LTC	\$ 13,500	Approved
2001	Providence AK Medical Ctr.	Anchorage	PET Scanner Purchase	\$ 3,200,000	Approved/Withdrawn later
2000	Bartlett Regional Hospital	Juneau	Major Remodel & Expansion	\$ 51,000,000	Approved
2000	Alaska Regional Hospital	Anchorage	Remodel & Additional surg space	\$ 13,150,000	Approved
1999	Tanana Valley Clinic	Fairbanks	2-suite ASC	\$ 4,206,722	Denied
1999	Fairbanks Ambulatory Surg. Ctr	Fairbanks	2-suite ASC	\$ 5,509,500	Denied
1999	Fairbanks Memorial Hosp.	Fairbanks	1-suite ASC	\$ 1,343,130	Denied
1999	South Peninsula Hospital	Homer	Remodel & add 10 NH Beds	\$ 9,236,756	Approved 5 beds, \$9.2M
1999	Providence AK Medical Ctr.	Anchorage	Remodel/Expand ER/N. Tower	\$ 25,000,000	Approved as Requested
1999	Alaska Psychiatric Institute	Anchorage	54 Bed Replacement	\$ 50,900,000	Withdrawn
1999	Fairbanks Memorial Hosp.	Fairbanks	11 bed MH expansion	\$ 3,400,000	Approved as Requested
1999	Valley Hospital - Palmer	Mat-Su Valley	Major Renovation	\$ 10,000,000	Approved as Requested
1999	Central Peninsula Hospital	Soldotna	MRI	\$ 1,400,000	Approved as Requested

Attachment # 2

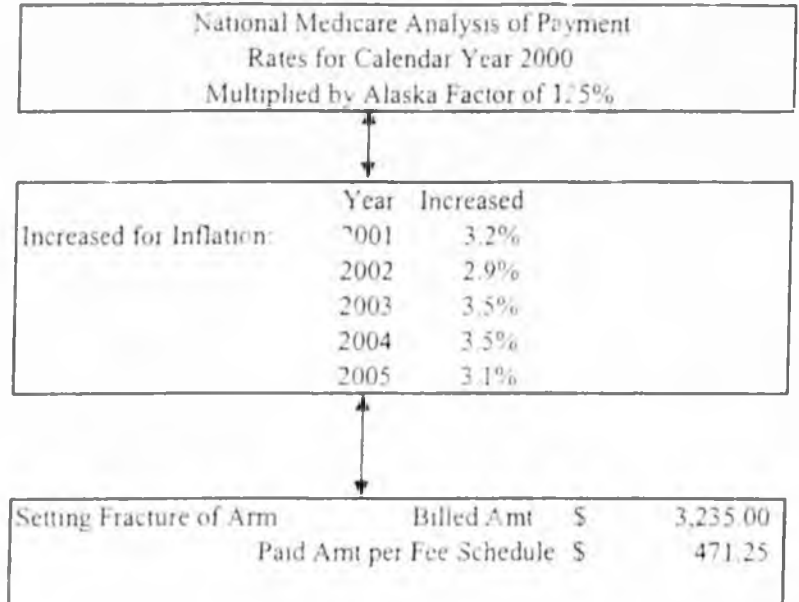
1998	Alaska Regional Hospital	Anchorage	Open Heart S.../Trauma	\$	1,300,000	Approved/1-OH suite shown in to 03
1998	Alaska Regional Hospital	Anchorage	Open Architecture MRI	\$	1,300,000	Approved as Requested
1998	Fairbanks Surgery Center	Fairbanks	Extension of Time Period	\$	2,900,000	Denied
1998	St. Ann's Care Center - Juneau	Juneau	44-Bed Nursing Home/replacement	\$	18,500,000	Approved as Requested
1997	Providence AK Medical Ctr.	Anchorage	Remodel/Expand Heart Ctr.	\$	1,520,000	Approved as Requested
1997	Bartlett Regional - Juneau	Juneau	Expand OR/Outpatient/New Adm	\$	6,800,000	Approved as Requested
1997	Valley Hospital - Palmer	Mat-Su Valley	60-Bed Nursing Home	\$	6,700,000	Withdrawn
1997	Providence AK Medical Ctr.	Anchorage	Childrens Hospital	\$	7,000,000	Approved as Requested
1996	Providence AK Medical Ctr.	Anchorage	Cardiac Cath Lab Expansion	\$	3,499,908	Approved as Requested
1996	Providence Seward Med Ctr	Seward	Replacement Facility	\$	7,800,000	Approved as Requested

Treatment for Fractured Arm

Outpatient Hospital Treatment

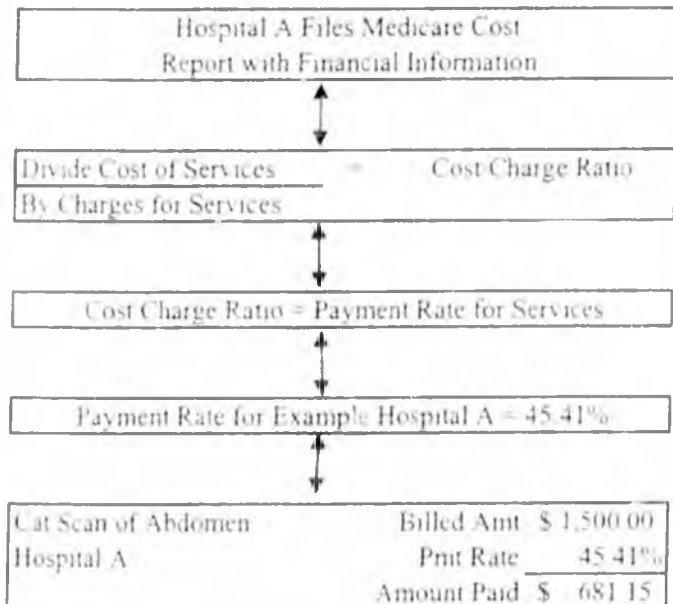


Ambulatory Surgical Center

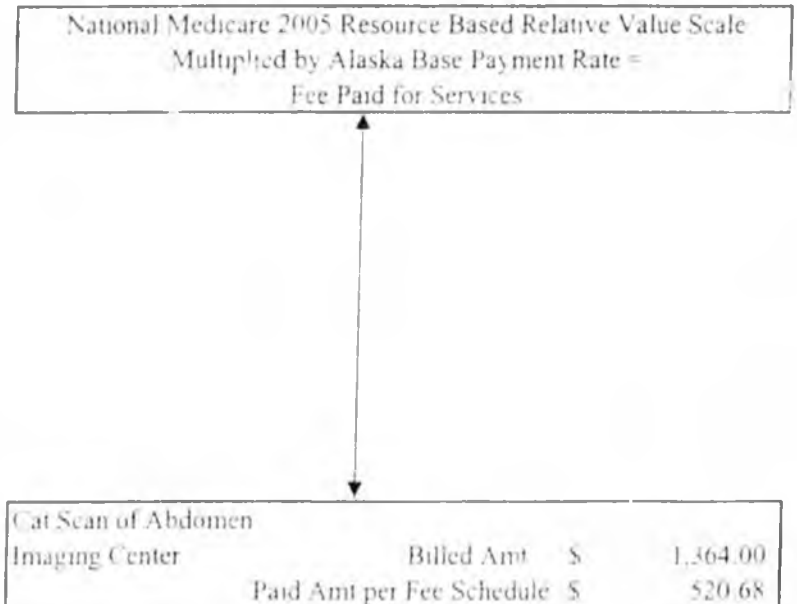


Cat Scan of Abdomen

Outpatient Hospital Treatment



Imaging Center



Alaska State Legislature

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Military & Veterans' Affairs Committee

Member

Labor and Commerce Committee

State Affairs Committee

Economic Development, Trade & Tourism
Committee

Education Committee

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Labor & Workforce Development

Community & Economic Development

Military & Veterans' Affairs



A Communication From

REPRESENTATIVE BOB LYNN

District 31 Anchorage

E-Mail: Representative_Bob_Lynn@legis.state.ak.us
"Bob Lynn's Alaska Blog" AlaskaDistrict31.blogspot.com

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March 23, 2006

Ms. Karleen Jackson, Commissioner
State of Alaska
Department of Health and Social Services
P.O. Box 110601
Juneau, Alaska 99811-0601

Dear Commissioner Jackson,

Thank you for your letter of March 13, 2006 concerning the fiscal note for HB 287. Much of the information is useful, but I am still having difficulty understanding the specific mechanism by which HB287 adds costs to Medicaid. Perhaps answers to specific questions will help me.

It's still not clear to me what part of HB 287 will cause Medicaid costs to increase.

1. Would HB 287 cause an increase in the number of eligible Medicaid recipients? If so, how?
2. Would HB 287 cause additional services to be offered which are not currently available to Medicaid recipients in Alaska? It is my understanding that, if services are not available in Alaska, Medicaid recipients will be sent to outside facilities to receive treatment. If people don't have to be flown out for treatment, wouldn't the cost be lower?
3. Why would HB 287 cause services to be more expensive than what is charged by existing providers? According to the pricing worksheet you provided in your example of a fractured arm, both procedures were less expensive (more than 50% less) than the same procedure provided in a hospital setting. If these numbers are accurate, then would not HB 287 have a negative fiscal note indicating the savings to the State?

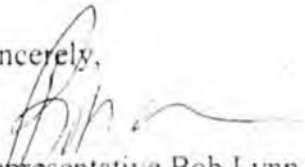
Letter/Commissioner Jackson
March 23, 2006
Page 2

4. You claim that providing services in facilities that would qualify for the additional facility fees could cause Medicaid costs to go up, for example Medicaid subsidies such as the DISH payments to hospitals. But in your letter dated March 13, you indicated that the only facility you could imagine in this category would be a surgery center physically connected and adjunct to a hospital. So if none of the facilities would be paid more, how would this generate a higher fiscal note?

Please help me understand how any of these items mentioned above would apply to HB 287. Is there some other mechanism that increases Medicaid costs?

Thank you in advance for your help on the questions mentioned above. Currently, HB287 has been scheduled for a hearing in House HESS Committee on March 28. It would be appreciated if I can get a **written response** before that time.

Sincerely,



Representative Bob Lynn

cc: Representative Coghill
Representative Chenault
Representative Kohring

Outdated Law Is Driving Up Health Care Costs for Alaskan's

Alaska's rising health care costs are hurting our families, raising worker's compensation costs, putting health care insurance out of economic range for individuals and companies, and raising Medicaid and Medicare costs throughout the state. A driving force behind our increasingly high medical costs can be attributed to a little known and archaic state law called Certificate of Need (CON).

In 1974 Congress passed a law requiring all the states to implement Certificate of Need programs requesting permission from their respective states in order to build and maintain medical facilities. If states did not comply the federal government would withhold funding, creating strong incentives for states to implement far-reaching health care planning regulations. In the 1980's the philosophical shift to promoting competition in the health care industry in order to reduce prices fueled significant controversy regarding CON regulations. As a result, in 1986 Congress repealed the federal CON requirements, but nevertheless Alaska has kept the law intact.

Alaska's Certificate of Need law requires medical facilities to receive state approval before construction of new clinics or surgery centers; an anti-competitive activity that would be severely punished by federal anti-trust laws if attempted by private companies but is sanctioned and promoted by the state of Alaska. This law directly stifles price competition by blocking new competitors from entering the market. So significant are these restrictions to competition and reduction in costs that every state West of the Missouri (save for Washington) has since repealed or significantly minimized the CON requirements. Alaska currently maintains the second most restrictive CON regulations in the country, behind only Connecticut. It doesn't take an economist to understand that increased competition results in lower prices for the consumer, something this state desperately needs.

A House Bill (#287) was introduced last April which would repeal CON laws in Alaska except in communities of 25,000 or less. This Bill, if passed, would have tremendous economic effect on the residents of Alaska in the form of huge health care savings by effectively wresting the monopolistic control hospitals exert on our residents health care costs. It would allow surgery centers to compete with hospitals for consumers the way every other industry must. The result of such competition would be lower prices, increased access, and more efficient care.

Unfortunately for all of us, House Bill 287 has yet to be heard in the House of Representatives and is therefore being denied the opportunity for approval. Representatives Bob Lynn, John Coghill Jr., Mike Chenault, and Vic Kohring should be commended for keeping the best interests of Alaskan's at heart by sponsoring this Bill. It is now these very residents however, who are burdened with the public support required to have this Bill heard in the House. Contact your Representatives and Senators today in support of House Bill 287; it's about time Alaskan's are given an answer to their quest for affordable medical care.

Paid for by Advanced Medical Centers of Alaska
1617 Abbott Road, Suite 108, Anchorage, AK 99507

Juneau Empire
3-19-06



Alaska Physicians & Surgeons, Inc.

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APS News

Nov/Dec
2005

www.apsdoctors.org

2005 APS Year-end Review

2005 will be remembered as APS' and the medical communities most successful legislative year in the past two decades. With passage of real, meaningful medical liability reform, Alaska has vaulted into the top tier of states that have taken the problem of our out of control medical tort system seriously. The new lower caps on non-economic damages should help stabilize the medical liability insurance market in Alaska. However, the law will be challenged by the trial bar, and to defend it APS has teamed up with several other entities and associations to form the Alaskans for Access to Healthcare (AAHC). AAHC is in the fight for the long haul because challenges to laws like this typically take between 3-6 years to reach the Supreme Court of Alaska. APS will be there every step of the way.

Two of APS' 2005 legislative priorities will carryover into 2006; 1.) amending the Alaska Healthcare Decision Act to cure several unintended consequences that affect the patient/physician relationship, and 2.) monitor the legislature's efforts as it attempts to address imbalances in Alaska's Workers Compensation system.

In early November the APS Board of Directors held its annual strategic planning meeting to set APS' 2006 legislative and other priorities.

In addition to the issues carried over from 2005, new initiatives will be:

Welcome New APS Member (s): John Lapkass - Orthopedic Surgeon

1.) to seek passage of an Alaska "Any Willing Provider" statute, 2.) elimination of Alaska's ineffective and anti-competitive Certificate of Need Law, 3.) support and help find funding for expansion of the WAMI program to 20 slots, and 4.) continue to raise funds through APS' Political Action Committee (APSPAC) to support physician and patient friendly legislative candidates.

It should be noted that APSPAC has been hugely successful this year and is now the largest and best funded physician directed PAC in Alaska. In September APSPAC in conjunction with ASMA's PAC (ALPAC) held a political fundraiser in Girdwood and over \$60,000 was raised, propelling Alaska's physicians into the top ranks of fundraisers in the state.

Amerinet 2005 Contract Utilization

APS' relationship with Amerinet, our group purchasing organization, continues to blossom. More member offices are taking advantage of the hundreds of discounted contracts that Amerinet has negotiated with local & national vendors for office supplies, pharmaceuticals, medical supplies and equipment, and much more. 2005 will be our best year ever with total activity and sales volume up by over 30% to well over 3 million dollars. For more information on buying opportunities contact the APS office at 561-7705.

Board of Directors:

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Paul Steer, MD
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Mark Your Calendars... APS Annual Dinner Meeting

Date: Tues, January 17, 2005

Time: 6:00 pm - 8:00 pm

Place: Hotel Captain Cook -
Fore Deck

(Invitations will be sent in December)

Countrywide Mortgage Offer to APS Member Offices and Staff

If you are considering refinancing or buying a home you may want to contact Countrywide Mortgage soon. APS members have saved thousands of dollars by financing through Residential Mortgage in the past. Jeff Stanford formally of Residential has moved to Countrywide and has offered the following Countrywide Mortgage discounts to APS members and their staff.

- No loan origination fee
- No cost equity loans
- No underwriting fee/processing fee
- Guaranteed lowest jumbo rates in Alaska
- 1% interest rates available up to 1 million

For further information you can contact Jeff Stanford Mortgage Loan Originator directly at 343-3636.

Fairbanks Daily News-Miner

Group wants health care law changed

By STEFAN MILKOWSKI
Staff Writer

Thursday, January 19, 2006 - A group of legislators and health-care providers is pushing to drastically reduce the reach of the state law governing development of new health care infrastructure.

Supporters would change the certificate of need law, which requires developers of medical facilities to prove that the facilities are needed, to cover only long-term nursing care facilities and residential psychiatric treatment centers.

Lt. Gov. Loren Leman approved petition language Tuesday for an initiative effort to change the certificate of need law. The initiative is similar to one proposed last year and to a bill introduced in the state House of Representatives in 2005.

Rep. Bob Lynn, R-Anchorage, sponsored the legislation as well as this year's ballot initiative.

"We're trying to protect free enterprise," he said. "If we can have more competition, it's likely we can have lower costs."

The issue promises to be contentious.

The certificate of need legislation was designed to prevent "excessive, unnecessary, or duplicative development of facilities or services," according to the Department of Health and Social Services' Web site.

The DHSS, which administers the certificate of need program, warns that limiting the legislation to nursing care and mental health facilities could actually cause an increase in statewide health care costs rather than the decrease promised by proponents of the new initiative.

The effective gutting of the law could eventually put some hospitals out of business, said Rep. Paul Seaton, R-Homer and vice-chairman of the House Committee on Health, Education and Social Services.

The initiative is sponsored by Reps. Lynn and Vic Kohring, R-Wasilla, and Paul Fuhs, a lobbyist.

A coalition of independent health-care facility owners, doctors and small business owners swamped by health insurance premiums supports the initiative, Fuhs said. Supporters formed the nonprofit organization Alaskans For Medical Choice and Competition to promote the change.

Alaska Open Imaging Center, which opened its fourth statewide facility Monday in Fairbanks, is a member of the group. The company skirted certificate of need regulations because the new facility qualifies as a physicians' group rather than an independent testing facility.

In 2005, Fuhs helped draft an initiative that would have eliminated certificate of need requirements for

urban Alaska and left them in place for rural Alaska. The initiative was not certified by Leman because it included "local and special legislation," which is prohibited from initiatives by the Alaska Constitution.

House Bill 287, introduced in April 2005 by Lynn, Kohring, Rep. John Coghill, R-North Pole, and Rep. Mike Chenault, R-Nikiski, would make the same changes and is not prohibited by the constitution.

On Tuesday, Leman certified the rewritten initiative, which Fuhs described as a "backstop." If HB 287 is passed, the initiative will likely be dropped, he said, as either would accomplish the group's goal.

In order for the initiative to reach the ballot, sponsors will need to collect 31,451 signatures from registered Alaska voters, reflecting 10 percent of votes cast in the 2004 general election.

Lynn said he supports the initiative both on principle and for its practicality.

Under the current law, someone seeking to create a health-care facility has to go "hat in hand" to the government and beg, he said.

"We should have the freedom to open any kind of business," he said.

Lynn said the bill was practical because the competition it allowed would lower health-care prices and increase quality.

He likened it to a customer having 100 cars to choose from or one.

"It's just that simple," he said.

Others argue it's not.

Rep. Sharon Cissna, D-Anchorage and a member of the health committee, said she also recognizes the strain placed on health-care consumers and providers by high costs of care. Most of the communities she has visited are facing troubles with health-care costs, she said.

"I don't think HB 287 is how you fix that," she said.

Cissna said limiting the certificate of need law would allow private companies to compete with hospitals on the most lucrative medical services and eventually threaten their livelihood.

Seaton, vice-chairman of the House health committee, said the most lucrative services, such as surgery and testing, help hospitals pay for "charity care," or care provided to patients with minimal or no insurance, as required by law.

Taking that business away from hospitals is "really problematic to maintaining an adequate health-care system for Alaskans," he said.

Representatives from Fairbanks Memorial Hospital did not return calls for comment.

The DHSS estimates that the law change could allow up to \$373 million to be spent on new health-care

facilities across the state, including walk-in surgery centers, general- and acute-care hospitals and independent diagnostic and testing facilities in Fairbanks, according to information provided by Lemman's office.

The new facilities could increase Medicaid costs to the state by \$20.6 million annually, according to the DHSS calculation.

Advocates of changing the law point to a report published in 2004 by the U.S. Department of Justice and the Federal Trade Commission.

The report found that, "On balance, CON programs are not successful in containing health care costs. ... Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market."

Staff writer Stefan Milkowski can be reached at smilkowski@newsminer.com or 459-7577.