Certificate of Need Initiative Certified

For Immediate Release: January 17, 2006

Lieutenant Governor Loren Leman today certified an application for an initiative petition amending the certificate of need requirement to apply only to facilities providing long term nursing home beds and residential psychiatric treatment centers.

The initiative's prime sponsors are Paul Fuhs, Representative Vic Kohring and Representative Bob Lynn.

Sponsors will need to collect 31,451 signatures from registered Alaska voters to qualify the initiative for a vote of the people. This is 10 percent of the 314,502 votes cast in the 2004 general election. Under the constitutional amendment approved by voters in 2004, signatures are needed from at least seven percent of voters in at least 30 of the 40 Alaska House Districts. Sponsors will have one year from the time they receive petition booklets to collect the required signatures.

This is the first initiative subject to the requirements of HB 94 (FSSLA 2), which had an effective date of September 22, 2005. This bill requires the Division of Elections to estimate the cost to process and review each initiative, and each affected department to estimate the minimum costs to the State associated with the initiative.

The Department of Health and Social Services estimates that this change could allow health care construction capital expenditures of up to $373.4 million without review by the Department. This could increase Medicaid costs by up to $41.2 million annually, of which $20.6 million would be State General Funds, for operations and depreciation expense under the current Medicaid rate-setting statutory and regulatory process. The Division of Elections estimates it will cost $39,800 to review and process this initiative. **Click here** for the full explanation of estimated costs.

To view the Department of Law recommendation for this initiative **click here**. To view the certification letter for this initiative **click here**. To view the text of the proposed initiative **click here** for The Division of Elections web site.

Note: Initiative petitions are not "approved" or "disapproved" by the Lieutenant Governor, rather they are "certified" or "not certified." State law specifies criteria that must be met for an initiative to be certified.

Potential Alaska Projects if CON is Eliminated for all but Residential Psychiatric Treatment Centers and Nursing Home Beds						
Type of Facility	Locations	Est. No. of Units	Estimated Facility Life	Annual Cost to Medicaid*	Estimated Total Construction Cost	Estimated Construction Cost per Unit
Ambulatory Surgery Centers	Juneau, Homer, Soldotna, Fairbanks, Anchorage, Mat-Su	40 Suites	25 years	$ 2,857,143	$ 62,782,410	$ 1,569,560
Long-Term Acute Care Hosp	Mat-Su, Fairbanks	90 Beds	25 years	$ 4,297,174	$ 31,800,000	$ 353,333
Cardiac Hospital	Anchorage	30 Beds	25 years	$ 3,925,139	$ 10,600,000	$ 353,333
Cardiac Cath Lab	Anchorage, Mat-Su, Fairbanks, Soldotna	4 Labs	5 yrs equip, 25 yrs bldg	No Data	$ 10,000,000	$ 2,500,000
Psych Hospital	Fairbanks, Anchorage	90 Beds	25 years	$ 14,452,739	$ 26,587,530	$ 295,417
Independent Diagnostic & Testing Facilities	Juneau, Sodotna, Fairbanks Mat-Su, Anchorage	7 Facilities	5 yrs equip; 25 yrs bldg	No Data	$ 28,700,000	$ 4,100,000
General Acute Care Hospitals	Fairbanks, Mat-Su, Anchorage	200 Beds	25 years	$ 11,775,418	$ 179,473,700	$594,737-$1,120,000
Kidney Dialysis	Anchorage	16 Stations		No Data	$ 2,000,000	$ 2,000,000
Radiotherapy	Anchorage, Fairbanks	2 Programs	5 years Equip	No Data	$ 8,200,000	$ 4,100,000
PET/CT Scanner	Anchorage	1 New	5 years	No Data	$ 3,200,000	$ 3,200,000
Orthopedic Hosp	Anchorage	30 Beds	25 years	$ 3,925,139	$ 10,600,000	$ 353,333
				$ 41,232,752	$ 373,943,640	
	*Includes operating and construction costs					

Estimated Costs for Reviewing and Processing 05CHA2 Petition

PERSONAL SERVICES:								$38,631.29
	PCN	Name	R/S	Salary	Bens.	LOC	HIRING PERIOD	
FULL-TIME PERMANENT:								$4,707.77
Election Coord.	502X	Allred	17F	$3,033.00	$944.48	AWA	Full-time for 15 days	$3,977.48
Elec Prg Asst	525X	Noss	10B	$556.88	$173.41	AWA	Full-time for 5 days	$730.29
TEMPS:								$33,923.52
Petition Clerk		Temp	8A	$7,769.93	$710.95	AWA	Full-time for 81 days	$8,480.88
Petition Clerk		Temp	8A	$7,769.93	$710.95	AWA	Full-time for 81 days	$8,480.88
Petition Clerk		Temp	8A	$7,769.93	$710.95	AWA	Full-time for 81 days	$8,480.88
Petition Clerk		Temp	8A	$7,769.93	$710.95	AWA	Full-time for 81 days	$8,480.88
PRINTING:								$400.00
TRAVEL:								$806.00
Airfare	$500							
Per Diem	$75							
Lodging	$170							
Rental Car + Gas	$36							
Cab Fare	$25							
TOTAL								$39,837.29

MEMORANDUM

State of Alaska
Department of Law

To: The Honorable Loren Leman
Lieutenant Governor

Date: January 12, 2006

File No: 663-06-0076

Tel. No.: (907) 465-3600

Sarah J. Felix

From: Sarah J. Felix
Assistant Attorney General
Labor and State Affairs – Juneau

Subject: Review of Initiative Application on Certificate of Need for Long Term Nursing Home and Residential Psychiatric Treatment Centers

I. INTRODUCTION AND SUMMARY

You have asked us to review an application for an initiative petition entitled "An Act amending the certificate of need requirement to apply only to facilities providing long term nursing home beds and residential psychiatric treatment centers." We have completed our review and find that the application complies with the constitutional and statutory provisions governing the use of the initiative. Under these circumstances we recommend that you certify the application.

II. SUMMARY OF THE PROPOSED BILL AND ANALYSIS

A. SUMMARY

Current law requires that expenditure of more than $1 million for the construction of a health care facility, alteration of the bed capacity of a health care facility, or expanding a health care facility to provide a new category of health services must be preceded by the issuance of a certificate of need from the Department of Health and Social Services. *See* AS 18.07.031(a). In addition, this law requires a certificate of need from the Department before a building can be converted to a licensed nursing home. AS 18.07.031(b). For a discussion of the background of the certificate of need program, please *see* 2005 Inf. Op. Att'y Gen. 2 (Oct. 12; 663-06-0049).

This bill would eliminate certificate of need requirements for all facilities except "a long-term nursing home or a facility providing nursing home beds or a residential

psychiatric treatment facility."[1] We note that the title of the bill uses somewhat different terms than the text of the proposed bill. The title refers to "residential psychiatric treatment centers," while the text of the bill amending AS 18.07.111(8) refers to "a residential psychiatric treatment facility." Similarly, the title of the bill refers to "facilities providing long term nursing home beds," while the bill's text in the proposed amendment to AS 18.07.111(8) refers to "a long-term nursing home or a facility providing nursing home beds." The Department of Health and Social Services indicates that it is extremely careful in defining the term "nursing home facility" because these facilities are subject to specific requirements in order to receive Medicaid reimbursement. The proposed bill's imprecision in drafting may raise issues regarding implementation of the bill if it is enacted. However, imprecision in drafting is not a ground for rejection of an initiative application. *See* 1991 Inf. Op. Att'y Gen. at 5 (Jan. 1; 663-90-0141).

The proposed bill is very different from the bill proposed by an initiative application submitted by these sponsors earlier this year addressing certificate of need. Our office reviewed the earlier initiative application in 2005 Inf. Op. Att'y Gen. (Oct. 12; 663-06-0049). In our earlier opinion we recommended that you deny certification because the proposed bill included prohibited local and special legislation. The bill proposed by the earlier initiative application would have eliminated the certificate of need requirements for urban Alaska, but maintain them in rural Alaska. In our earlier opinion we suggested that the sponsors could avoid the local and special legislation issue in the

---

[1] The terms "long term nursing home," and "facility providing nursing home beds" are undefined in AS 18.07.021—AS 18.07.111, and in the bill proposed by this initiative application. However, "nursing home bed" is defined in AS 18.07.111(9) as "a bed not used for acute care in which nursing care and related medical services are provided over a period of 24 hours a day to individuals admitted to the health care facility because of illness, disease, or physical infirmity." "Residential psychiatric treatment center" is defined in AS 18.07.111(10) as

> a secure or semi-secure psychiatric facility or inpatient program in a psychiatric facility that is licensed by the Department of Health and Social Services and that provides therapeutically appropriate and medically necessary diagnostic, evaluation, and treatment services.
>
> (A) 24 hours a day for children with severe emotional or behavioral disorders;
>
> (B) Under the direction of a physician; and
>
> (C) Under a professionally developed and supervised individual plan of care designed to achieve the recipient's discharge from inpatient status at the earliest possible time that is intensively and collaboratively delivered by an interdisciplinary team involving medical, mental health, education, and social service components.

bill by eliminating certain categories of facilities from the certificate of need statute. *Id.* at 4. The sponsors have changed the proposed bill so that it no longer eliminates the certificate of need requirement for urban Alaska while retaining the requirement for rural Alaska. Instead, the proposed bill now requires a certificate of need for certain types of health care facilities, and eliminates the requirement for other types of facilities. By making this change the sponsors have eliminated the "local and special legislation" problem in the current application. Under the current bill, hospitals, facilities for independent diagnostic testing, kidney disease treatment, intermediate care, and ambulatory surgery would no longer be subject to the certificate of need requirement.

The bill proposed in the current application contains a number of introductory clauses indicating that the certificate of need requirement limits medical choices and prevents competitive, lower prices for health care costs. The last of these "whereas" clauses indicates that a majority of states either have no certificate of need regulations or limit regulation to long term nursing home beds to help control government costs. The bill then sets out a very brief description of proposed revisions to the certificate of need statutes, repealing AS 18.07.041, revising the definition of "health care facility" set out in AS 18.07.111, and directing that conforming amendments be made to Title 18, Chapter 7, to reflect the changes in the definition of health care facility. The new definition for "health care facility" set out in proposed AS 18.07.111(8), is "a long-term nursing home or a facility providing nursing home beds or a residential psychiatric treatment facility."

B. ANALYSIS.

Under AS 15.45.070, the lieutenant governor is required to review an application for a proposed initiative and either "certify it or notify the initiative committee of the grounds for denial." The grounds for denial of an application are that (1) the proposed bill is not in the required form; (2) the application is not substantially in the required form; or (3) there is an insufficient number of qualified sponsors. AS 15.45.080. We discuss these next.

1. The Form of the Proposed Bill

The form of a proposed initiative bill is prescribed by AS 15.45.040, which requires that (1) the bill be confined to one subject; (2) the subject be expressed in the title; (3) the enacting clause state, "Be it enacted by the People of the State of Alaska"; and (4) the bill not include prohibited subjects. The prohibited subjects—dedication of revenue, appropriations, the creation of courts or the definition of their jurisdiction, rules of court, and local or special legislation—are listed in AS 15.45.010 and in article XI, section 7 of the Alaska Constitution.

The bill is confined to one subject: certificate of need requirements for nursing home and psychiatric facilities. The subject of the bill is expressed in the title. The enacting clause is set forth correctly. The proposed bill does not contain a prohibited subject. As we explained above, the current bill does not limit application of the certificate of need requirement to rural Alaska, and instead limits the certificate of need requirement to certain types of health care facilities, while eliminating the requirement for other types of facilities. Therefore, the bill no longer contains prohibited local and special legislation. Accordingly, the bill is in the required form.

2. The Form of the Application

The form of an initiative application is prescribed in AS 15.45.030, which provides:

> The application shall include (1) the proposed bill to be initiated, (2) a statement that the sponsors are qualified voters who signed the application with the proposed bill attached, (3) the designation of an initiative committee of three sponsors who shall represent all sponsors and subscribers in matters relating to the initiative, and (4) the signatures and addresses of not less than 100 qualified voters.

The application meets the first three requirements. With respect to the fourth requirement, the Division of Elections within your office determines whether the application contains the signatures and addresses of not less than 100 qualified voters.

3. Number of Qualified Sponsors

As noted above, the Division of Elections within your office will determine whether there are a sufficient number of qualified sponsors.

III. PROPOSED BALLOT AND PETITION SUMMARY

We have prepared the following ballot-ready petition summary and title for your consideration:

Limit Certificate of Need Requirement

> This bill would amend the law that requires a person to obtain a certificate of need from the state before a health care facility

BE IT ENACTED BY THE PEOPLE OF ALASKA

The Consumer's Access to Competitive Health Care Act

" An Act amending the certificate of need requirement to apply only to facilities providing long term nursing home beds and residential psychiatric treatment centers."

Whereas: high and ever-rising health care costs are hurting Alaskan families, raising workers' compensation costs, putting health care insurance out of economic range for individuals and companies, and raising Medicaid and Medicare costs throughout Alaska;

And whereas: it is an accepted premise that competition brings higher quality services and lower prices to consumers;

And whereas: Alaska's certificate of need program needlessly limits medical choices for Alaskans and prevents competitive, lower prices for Alaskans through prohibitive government regulation;

And whereas: the US Departmen. of Justice and Federal Trade Commission have both identified certificate of need regulations as a major driver of rising health care costs in the United States for the states that maintain these regulations;

And whereas: a majority of states in the United States either have no certificate of need regulations or limit them only to long-term nursing home beds to help control government costs;

Therefore, be it enacted by the People of Alaska:

Repeal 18.07.041 Standard of Review for Applications for Certificates of Need Relating to non-nursing Home beds and Services.

Section 18.07.111 Definitions is amended to read:

(8) "health care facility" means a long-term nursing home or a facility providing nursing home beds or a residential psychiatric treatment facility.

Title 18 Chapter 7 Certificate on Need is further amended to provide conforming amendments to reflect the changes in the definition of health care facility.

CERTIFICATE

I LOREN LEMAN, LIEUTENANT GOVERNOR FOR THE STATE OF ALASKA, CERTIFY THAT the initiative application for, "An Act amending the certificate of need requirement to apply only to facilities providing long term nursing home beds and residential psychiatric treatment centers," has been reviewed and is in proper form as required under the provisions of Article XI of the Constitution of the State of Alaska and the provisions of AS 15.45.010 through AS 15.45.070.

I FURTHER CERTIFY THAT the application contained the signature and addresses of at least 100 qualified voters.

IN TESTIMONY OF THIS, I have signed this document and affixed the Seal of the State of Alaska, at Juneau Alaska,

This 17th day of January

A.D. 2006

Loren D. Leman

LIEUTENANT GOVERNOR

The initiative must be filed within one year from the date notice is given that the petition booklets are ready for delivery (AS 15.45.140). However, you should also be aware of the time requirements provided in AS 15.45.190 (copy enclosed). The petition must be signed by qualified voters at least equal in number to 10 percent of those who voted in the last General Election, who are resident in at least three-fourths of the House districts of the State and who, in each of these House districts, are equal in number to at least seven percent of those who voted in the preceding General Election in the House district.

The number of signatures that you need to gather will be based on the 2004 General Election (6 AAC 25.240 (i)). You will need at least 31,451 qualified voters in at least 30 election districts to sign the petition. The vote totals for each House district from the 2004 General Election are enclosed.

This is the first initiative subject to the requirements of HB 94, which had an effective date of September 22, 2005. HB 94 (FSSLA 2) requires the Division of Elections to estimate the cost to process and review each initiative, and each affected department to estimate the minimum costs to the State associated with the initiative.

The Department of Health and Social Services estimates that this change could allow health care construction capital expenditures of up to $373.4 million to be built without review by the Department. This could increase Medicaid costs by up to $41.2 million annually, of which $20.6 million would be State General Funds, for operations and depreciation expense under the current Medicaid rate-setting statutory and regulatory process. This estimate does not include potential increases in costs to the general public related to facilities raising prices because of under-utilization, or the potential for facilities in small markets to request exceptional relief if they experience financial difficulties. The Division of Elections estimates it will cost $39,800 to review and process this initiative.

If you have questions or comments about the initiative application certification, please contact my special assistant, Lauren Yocom, at 465-4082.

Sincerely,

Loren Leman

Loren Leman
Lieutenant Governor

Enclosures

cc: Representative Vic Kohring, Initiative Committee Member
Representative Bob Lynn, Initiative Committee Member
Michael Barnhill, Assistant Attorney General, Department of Law
Whitney Brewster, Director, Division of Elections

State Capitol
Juneau, Alaska 99801
907.465.3520 465.5400 FAX
www.ltgov.state.ak.us

550 West 7th Ave, Suite 1700
Anchorage, Alaska 99501
907.269.7460 269.0263 FAX
Lt_Governor@gov.state.ak.us

Lieutenant Governor Loren Leman

January 17, 2006

Mr. Paul Fuhs
329 E 10th Ave
Anchorage, AK 99501

Dear Mr. Fuhs:

You submitted to me an initiative application for a bill entitled, "An Act amending the certificate of need requirement to apply only to facilities providing long term nursing home beds and residential psychiatric treatment centers," for review under AS 15.45.070. I forwarded it to the Division of Elections for verification of signatures and the Department of Law for legal review.

The petition statistics report prepared by the Division of Elections and the Department of Law's opinion regarding your application are enclosed.

The Division of Elections verifies that your application has a sufficient number of sponsors to qualify for circulation of a petition. The Department of Law concludes that the initiative application complies with AS 15.45.030 and AS 15.45.040. Consequently, I certify your initiative application as being in the proper form under the provisions of AS 15.45.010 through AS 15.45.070, and Article XI of the Alaska Constitution. Your official certificate is enclosed.

As Lieutenant Governor and in accordance with AS 15.45.090 (2), it is my duty to prepare an impartial summary for the petition booklets. The following is the petition summary I propose:

Limit Certificate of Need Requirement

> This bill would amend the law that requires a person to obtain a certificate of need from the state before a health care facility can be built. It would remove certain facilities from the requirement. A certificate of need would no longer be required for new hospitals or facilities for diagnostic testing, treatment of kidney disease and day surgery. A certificate of need would still be required for long-term nursing care and residential psychiatric treatment care facilities.
>
> Should this initiative become law?

The Division of Elections will prepare and print numbered petition booklets for circulation. As soon as the booklets are available, the Division will send them to the Division's regional office of your choice (Juneau, Anchorage, Fairbanks or Nome). At that time, you will also be provided with instructions for booklet distribution and accounting. These must be followed.

can be built. It would remove certain facilities from the requirement. A certificate of need would no longer be required for new hospitals or facilities for diagnostic testing, treatment of kidney disease and day surgery. A certificate of need would still be required for long-term nursing care and residential psychiatric treatment care facilities.

Should this initiative become law?

This summary has a Flesch test score of 41.702, which is lower than the target readability score of 60. However, given the need to use technical and multi-syllable words in the summary, we have made the ballot summary as readable as is possible. Given these circumstances, we believe that the summary meets the readability standards of AS 15.60.005.

IV. CONCLUSION

Assuming that the Division of Elections determines that there are a sufficient number of qualified subscribers, we conclude that this bill and application are in the proper form, and that the application complies with the constitutional and statutory provisions governing the use of the initiative. Therefore, we recommend that you certify this initiative application, and so notify the initiative committee. Preparation of the petitions may then commence in accordance with AS 15.45.090.

Please contact me if we can be of further assistance to you on this matter.

SJF/mi

cc: Whitney Brewster, Director
Office of Lieutenant Governor, Division of Elections

Stacie Kraly, Chief Assistant Attorney General
Department of Law, Human Services Section

ADVANCED MEDICAL CENTERS OF
ALASKA

1917 Abbott Road, Suite 100
Anchorage, AK 99507
(907) 278-2741phone
(907) 743-8284 fax

Grant T. Roderer, M.D. · Lawrence W. Stinson, M.D. · Jimmy M.Tamai, M.D.
Gregory R. Polston, M.D. · Nancy E. Cross, M.D. · Marc Slonimski, M.D.
Rafael L. Prieto, M.D. · Richard Cobden, M.D. · Deborah Kiley, ANP
Lois Michaud, Ph.D. · Connie Judd, ANP · Catherine Barrett, ANP

FACSIMILE TRANSMITTAL

To: HESS Committee Fax: (907) 465-3175

Company: _____ Phone: _____

From: Shauna Baughcum, Corporate Administrator Date: 3-28-06

Re: _____ Pages: 22
(including cover sheet)

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please call to confirm receipt ☐ Please reply

WASHINGTON POLICY CENTER

John Barnes, Policy Analyst
jbarnes@washingtonpolicy.org

Concerns regarding the fiscal note for Alaska's HB 287 (2006)

Scaling Down Certificate of Need Requirements

- Too little explanation of the fiscal note estimates. How *exactly* did they arrive at these numbers? This is especially important if the crux of the argument against scaling down CON laws is the fiscal impact on the state.

- The department predicts $2.7 million in expenditures for Cardiac Hospitals starting in FY2010, but admits there have not been any specific inquiries for such facilities.

- The department admits uncertainty with the numbers for various reasons, but insists their estimates are "conservative." This does not make sense. If this is true uncertainty, then their estimates could be high as well.

- In general, the department makes estimates and projections for several years down the road. You cannot assume this to be accurate. Financial estimates for that far out are laden with problems because of shifting variables and unpredictable circumstances. The general unreliability of state projections and projection methodologies is a large reason why CON laws do not help control health care costs. You cannot centrally-plan for the present or the near future, much less 6 or 7 years down the road.

- The department makes a $2.7 million projection for Orthopedic Hospitals without providing demonstration of interest. They state simply that "it is only a matter of time before they move to Alaska," and make a projection for FY2012. Fiscal notes ought not be based on the *supposed* inevitability of anything, and a projection for 6 or 7 years down the road is informed speculation at best due to shifting economic and demographic factors.

- In general, the calculation methodology (that which can be seen, at any rate) is suspect. The department is basing its estimation of facilities that would be built in a post-CON era on letters of intent and applications received in the past. But letters and applications are filed with the understanding that CON may not be granted. They are filed in an attempt to enter a market where providers are insulated from competition, where success is much more assured. When there is no CON barrier, providers have to be more careful in deciding to enter the market, and some who filed letters and applications would not actually proceed with projects because the likelihood for success changed. **You cannot assume that the number of letters and applications reflect the likely number of new facilities.**

- The fiscal note is based on the *assumption* that a massive supply surge will follow a CON downscaling. That is not necessarily true. A 1998 empirical study published in *Journal of Health Politics, Policy, and Law* examined health spending between the late 1970s and 1993

and found that in states that repealed CON laws, there was no surge in health spending.[1] This evidence contradicts the fiscal note's projections. [If this surge does occur, it will reflect the fact that the supply was abnormally depressed due to CON in the first place. In the long run Alaska will experience a leveling off of supply that reflects true demand.]

- A 2003 study by three leading authorities in the field of health policy found that aggregate state-level data from 1981 through 1998 shows states that repealed their CON and moratorium laws had no significant growth in either nursing home or long-term care Medicaid expenditures.[2] This evidence contradicts the fiscal note's projections, and *even if these facilities are not included in the bill, this evidence calls into question the department's methodology for fiscal impact and its assumptions in general.*

- Fiscal note numbers do not reflect the potential for cost reduction in the aftermath of CON downscaling. CON laws curtail services and facilities, often forcing patients into more expensive substitutes, thus increasing costs for patients or third-party payers. EXAMPLE: if nursing home beds are not available, the discharge of patients from more expensive hospital beds may be delayed or patients may be forced to use a more expensive nursing home.

- Fiscal note numbers do not take into account the potential for savings through reduced administrative costs, less personnel time, etc. If less time and resources are being spent running CON, that's money saved. This is true for business as well. Many businesses have entire departments devoted to just the CON process.

[1] Christopher Conover and Frank Sloan, "Does removing certificate-of-need regulations lead to a surge in health care spending?" *Journal of Health Politics, Policy, and Law*, Vol. 23, Issue 3.

[2] David C. Grabowski, Robert L. Ohsfeldt, and Michael A. Morrisey. "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures," *Inquiry* 40 (Summer 2003): 146-157.

BEYOND HEALTH CARE REFORM: RECONSIDERING CERTIFICATE OF NEED LAWS IN A MANAGED COMPETITION SYSTEM

PATRICK JOHN MCGINLEY[*]

I. INTRODUCTION

America is spending nearly a trillion dollars annually on health care.[1] Although neither state nor national legislators can agree on the details, the focus of health care reform has been the "managed competition" model. Managed competition intends to control health care costs by encouraging price competition among health care providers.[2] In a typical managed competition plan, such as that recently enacted in the state of Florida, a state agency negotiates on behalf of many purchasers in order to demand lower prices from providers.[3] Managed competition, therefore, attempts to lower costs by managing demand.

Supply, and not demand, was the emphasis of early health care regulation.[4] "Certificate of need" (CON) laws were designed to keep health care costs low by requiring advance approval by state agencies for most hospital expansions and major equipment purchases.[5] Congress required all states to pass CON laws in 1974, but quickly repealed that requirement after finding it ineffective for controlling health care costs.[6]

Today, thirty-eight states retain CON laws.[7] Many of these same states have passed managed competition laws.[8] This Comment will explore the role of CON laws in a state with a managed competition system.[9] Part II traces the origin and intent of CON, noting that CON has historically failed to achieve its intended policy goals.[10] Part III summarizes the origin and implementation of a managed competition health care strategy, illustrating that strong evidence demonstrates that managed competition can lower health care costs.[11] Part IV shows that managed competition invalidates the presumptions underlying the alleged need for CON.[12] Part V focuses on Florida, where the conflict between CON and managed competition is becoming reality, and urges Florida and similarly situated states either to scale back CON or accept the failure of managed competition that CON will inevitably cause.[13]

II. ORIGIN AND INTENT OF CERTIFICATE OF NEED REGULATIONS

Certificate of need is the common name for a diverse group of state health care laws attempting to control health care costs by regulating supply.[14] These laws require that a permit, usually called a certificate of need, be issued by a state health planning agency before a health care facility may construct or expand, offer a new service, or purchase equipment exceeding a certain cost.[15] A CON will not be issued unless a new facility or service is genuinely needed in a given community.[16] Although determining need can be problematic,[17] CON laws provide statutory and rule criteria to guide the issuing agency's discretion.[18]

A. State Origins

CON laws originated from local community efforts to allocate philanthropic and federal funding so that new hospitals would be built where they were most needed.[19] Throughout the Great Depression and World War II, few new hospitals were built in the United States, yet many existing hospitals became obsolete.[20] The ensuing crisis was exacerbated by an inadequate distribution of hospitals among and within the states.[21] In response, community fund-raising and charitable activities of the 1940's evolved into organized community plans for hospital development.[22] Community planning became particularly important in 1946 with the passage of the federal Hill-Burton Act.[23] Hill-Burton provided federal subsidies for hospital construction, and promoted local planning in order to identify local needs.[24] The local planners in some communities worked under nongovernmental auspices, while planners

in other communities worked as part of governmental health planning agencies.[25] For those communities without government-enforced health planning agencies, local plans were voluntary.[26]

Over time, voluntary planning waned, while compulsory, government-enforced planning flourished.[27] This was not necessarily the result of the Hill-Burton Act, because eighty-seven percent of the total funds required for voluntary hospital construction from 1946 to 1967 came from private fund-raising sources.[28] One explanation for why voluntary planning declined is the benefit that the hospitals received from mandatory regulation.[29] Mandatory regulation through health planning agencies helped identify the most urgent health needs, helped meet these needs through cooperative and consensual development, and helped curb the excessive cost increases and price decreases often caused by a competitive marketplace.[30]

Hospitals regulated by a health planning agency can collectively determine the size of a community's hospital bed supply, and thereby engage in output restriction.[31] Regulated hospitals can also collectively allocate areas of responsibility both geographically and by activity, and thereby engage in market division.[32]

These two activities—output restriction and market division—are classic characteristics of a cartel.[33] In fact, many of the output restriction and market division activities of early health planning agencies were indistinguishable from the activities of a cartel.[34] Critics frequently observe that "regulatory agencies tend to adopt strategies disturbingly similar to those which an industry-wide cartel . . . would pursue if it could."[35] In any cartel, centralized planning and sanctions against uncooperative members are essential if the participants are to avoid the effects of a competitive market.[36] The early mandatory health planning agencies provided the necessary planning and sanctions, and did so with the aid and permission of local governments.[37]

Hospitals have successfully organized to support and proliferate state CON laws. In 1964, New York became the first state to pass a statute of statewide effect[38] that required a governmental determination of need before any hospital or nursing home was constructed.[39] Just four years later, the American Hospital Association indicated its membership's acceptance of CON laws.[40] The American Hospital Association then began nationwide lobbying efforts to pass CON laws at the state level,[41] and even drafted a model state law.[42] By 1975, twenty states enacted CON laws.[43] By 1978, thirty-six states had enacted such laws.[44]

B. Congressional Origins

After 1978, almost all states enacted CON laws, primarily because the National Health Planning and Resources Development Act of 1974[45] provided substantial federal funding for state and local health planning activities.[46] Under the 1974 National Health Act,[47] certain federal health care funds were conditioned on the state's enactment of CON laws.[48] By 1986, forty-two states plus the District of Columbia had responded to Congressional pressure by enacting a CON program.[49] After 1986, however, Congress turned full circle, repealing the 1974 National Health Act and its requirement for state CON laws.[50] The reason for Congress' abandonment of CON is simple: the laws are counterproductive for reforming health care.

1. Why Congress Promoted Certificate of Need: The Legislative History

CON laws were expected to add "teeth" to the 1974 National Health Act.[51] Under the Act, Congress intended CON to achieve three health care goals. First and foremost, CON was to restrain skyrocketing health care costs.[52] Second, CON was to prevent the unnecessary duplication of health resources.[53]

Third and most ambitiously, CON was to achieve equal access to quality health care at a reasonable cost.[54] The legislative history of the National Health Act clearly enunciates these goals, yet does not clearly illuminate the social and economic situation which made these goals appear acceptable and necessary. The following addresses each of these legislative goals separately, supplementing each with information gathered from legal sources published at the time the Act was passed, or published after the Act with the intent of analyzing the Act's purpose. Through such an analysis, Congress's "three" reasons for CON are revealed to be just a single purpose: to reduce the aggregate cost of the nation's health care.

a. Restraining Skyrocketing Health Care Costs

The primary Congressional purpose in requiring CON laws was to save money.[55] Statistics compiled prior to the passage of the 1974 Act reveal the severity of the 1970s' health care crisis. For example, when Congress considered the National Health Act, medical care prices were rising at an annual rate of 16.6 percent,[56] hospital charges were rising at an annual rate of 18.7 percent,[57] yet the consumer price index was rising at a considerably lower annual rate of 13.7 percent.[58] The average cost of a single day in the hospital rose from nearly $16.00 in 1950, to almost $45.00 in 1965, and then to about $128.00 in 1974.[59] These figures show an alarming rate of increase in health care costs. At the time of the 1974 Act, as now, health care costs were out of control.[60]

b. Preventing the Unnecessary Duplication of Health Resources

The drafters of the 1974 National Health Act viewed the underutilization of health care resources as a primary cause of skyrocketing health care costs.[61] The 1974 National Health Act was "premised on the theory that the current structure and incentives of the health care industry lead to overinvestment and that unneeded . . . health care resources contribute significantly to rampant inflation in health care costs."[62]

The Senate committee drafting the 1974 National Health Act found that the need for additional hospital beds[63] in the nation had virtually disappeared.[64] As of 1974, 20,000 beds nationwide were underutilized to the point of being labeled "surplus," and the number of surplus beds was expected to exceed 67,000 by 1975.[65] Accordingly, the Act sought to remedy the "maldistribution of health care facilities and manpower."[66]

Congress adhered to the theory that the cost of excess supply was ultimately borne by third party purchasers, and then passed on to health care consumers in the form of higher premiums and cost for services.[67] According to Congress's theory, third party fee-for-service insurance agreements encourage providers to overindulge in capital investments.[68] Companies operating in a traditionally competitive market do not overindulge in capital investments because service and facility expansion benefits a company only if demand exceeds supply, or if efficiencies can be realized through economies of scale.[69] In Congress's theory, however, health care facilities do not respond to these typical pressures of a competitive market. Proponents of CON cite four reasons why health care facilities have the propensity to overinvest in capital investments: the externalization of purchase costs, the nonprice competition among providers, the physicians' effect on supply, and the "Roemer Effect" on demand.[70]

i. The Externalization of Purchase Costs

In the health care climate that created the 1974 Act, third party fee-for-service insurance agreements, such as those traditionally provided by Blue Cross/Blue Shield and the federal Medicare and Medicaid health insurance programs, were the dominant means of health care financing.[71] Third party fee-for-service insurance agreements, or "fee-for-service," reimburse health care providers retrospectively for

the costs of services rendered to insured patients.[72] In other words, fee-for-service agreements do not negotiate medical fees in advance, but instead negotiate payment after services are rendered and prices are set. Fee-for-service reimbursement rates typically include "overhead," such as the operating costs and capital expenditures of health care providers.[73] Congress believed that the overhead payments, although initially made by the third party insurer, are ultimately borne by the public through higher taxes due to Medicare/Medicaid[74] or through higher premiums charged by commercial insurers.[75] Health care facilities are therefore allegedly insufficiently deterred from unnecessary construction.[76] because costs are passed to the consumer in the form of higher fees. As a result, fee-for-service allegedly allows health care entities to overinvest in new facilities and equipment with diminished regard for public need or efficiency.[77]

Therefore, fee-for-service allegedly reduces the financial risks of excess capacity and overinvestment because health care providers directly recoup their investment costs.[78] However, this contention overlooks the monitoring effects of section 1122 review. The 1974 National Health Act's CON program was modeled after the earlier, and coexisting, section 1122 capital expenditure review provisions[79] of the Social Security Amendments of 1972.[80] Even after Congress mandated the passage of state CON laws, Medicare and Medicaid section 1122 reviews were allowing states to review capital expenditures and to deny reimbursement for expenditures which did not fit the state's health plan.[81] Section 1122 programs allow states, on a voluntary basis, to participate in reviewing capital expenditures made by health care facilities receiving federal funds under the Medicare and Medicaid subchapters[82] of the Social Security Act.[83] State planning agencies perform the section 1122 reviews, and may deny federal reimbursement for amounts attributable to depreciation, interest on borrowed funds, and return on equity capital if the agency finds that a health care facility's capital expenditure does not further state health planning needs.[84] Section 1122 review programs therefore sought the same result as CON laws by empowering state agencies to curb health care facility growth and expenditures by requiring conformance with a state health care plan. Stated somewhat differently, section 1122 and CON both seek the same goals using the same methods.

With 20/20 hindsight, it appears Congress was unwise in believing that CON would succeed in adequately controlling health care costs when the section 1122 review programs did not succeed. According to the legislative history, Congress was aware that CON laws achieved a purpose nearly identical to section 1122 review, and achieved this purpose by nearly identical means.[85] Recognizing this, a House of Representatives committee recommended amending the Senate bill so that CON laws would be required only in states which did not voluntarily engage in section 1122 review programs.[86] However, in a Conference Committee, a substitute bill was drafted omitting the House Committee's recommended amendment.[87] Thus, even in states already controlling capital expenditures under section 1122 review programs, CON laws were required[88] under the 1974 National Health Act.[89]

ii. The Non-Price Competition Among Facilities

Congress also believed that health care facilities were not only undaunted from making unnecessary construction and capital expenditures, but were actually *encouraged* to construct and expend by the pressures of non-price competition.[90] Hospitals cannot compete for patients or doctors based on price, so they compete for doctors and patients based on quality.[91] To most, competition based on quality would seem to be an acceptable behavior.[92] To proponents of CON, however, competition based on quality is socially undesirable.

Health care consumers, providers, and hospitals agree that quality means having the biggest, most elaborate, most modern facilities and equipment. "While health care regulators seek to rationalize the health care system, health care consumers want to feel that when family members fall ill, they will have convenient access to the best and most technologically advanced medical care."[93] Patients want to be

treated by hospitals using the latest and best technology and procedures, even if they do not "need" these facilities in the eyes of industry regulators.[94]

Hospitals have four reasons for wanting the best facilities and equipment: a concern for patients, a desire to attract new patients, a desire to attract the best physicians, and a desire "not to be regarded as a second-class institution."[95] The concern for patients is both altruistic and advantageous.[96] The desire to attract new patients is a necessity for the profitable operation of any health care facility.[97] The desire to attract physicians stems from a concern for patient welfare and a concern for the hospital's bottom line.[98] The desire "not to be regarded as a second-class institution" is a product of human vice, which some characterize as "institutional ego."[99] The four factors combine to motivate hospitals to invest, invest, invest. Physicians further fuel the hospitals' quest to invest by demanding the most modern facilities and equipment.[100]

iii. The Physician's Effect on Supply

A health care facility's financial risks from excess capacity and overinvestment are allegedly reduced because the primary decisions concerning health care services are made by the physician and not the ultimate health care consumer.[101] Doctors influence the amount of "services" supplied to a hospital. For example, good evidence exists that the number of surgeries performed is largely determined by the number of physicians available—the more surgeons trained, the more surgery patients supplied.[102] This phenomenon is not limited to surgeons, but extends to all medical professionals who potentially supply patients to a hospital. For example, "if his schedule is light, it is easy for Dr. Smith to tell Ms. Jones to come back every two weeks rather than once a month."[103] The health care system removes the "purchase" decisions from the "invisible hand" of the marketplace, and puts those decisions into the hands of the physician.[104] Physicians have an economic incentive to "sell" their "product," and therefore have a vested interest in generating supply.[105]

iv. The "Roemer Effect" on Demand

Just as physicians can allegedly generate supply, hospitals allegedly generate demand.[106] Statistics show that when more hospital beds are available, more hospital beds will be filled.[107] Likewise, when more physicians are available, more health care services will be used.[108] In short, the effect of excess supply of health services is the "manufacture" of demand.[109] This effect—the "Roemer Effect"—is named after the individual who first noted the relationship.[110]

Hospitals widely accept the statistic that an empty bed costs the hospital about two-thirds as much as an occupied one.[111] Applying this realization, hospitals can assume that a bed should be used if the value of hospitalization to the patient is at least one-third the total cost to the hospital.[112] Economics and social pressures give hospitals the motive and opportunity to generate demand for services.

In sum, Congress adopted the second goal of CON—preventing unnecessary duplication of health care costs—to combat four undesirable factors: the externalization of purchase costs, the non-price competition between facilities, the physician's effect on supply, and the "Roemer Effect" on demand. A closer analysis reveals that each factor is undesirable because each leads to an increase in the nation's health care costs. Therefore, Congress' second goal of CON is only an extension of Congress's first goal—restraining skyrocketing health care costs.

c. Achieving Equal Access to Quality Health Care at a Reasonable Cost

Congress's third goal—achieving equal access to quality health care at a reasonable cost—does not have

a direct connection to restraining costs.[113] Cost concerns were the paramount reason for the 1974 National Health Act's CON requirements, but the Act also intended CON to help achieve equal access to health care.[114]

However, CON was to be only one element in the equation creating equal access to health care; the most significant element was the anticipated passage of a national health insurance program.[115] Medicare, Medicaid, and the expected national insurance program would ensure universal access, and the role of CON laws was to control rising costs before Congress passed a national health insurance plan.[116] Of course, Congress never passed a national health insurance plan.[117] As a result, Congress's third goal was not addressed with any practical application, but was instead little more than lip service to a noble ambition. Therefore, Congress's "three goals" were in fact just one: a goal of reducing the nation's aggregate health care costs.

2. Why Congress Abandoned Certificate of Need: The Legislative Reality

Four years after the enactment of CON, Congress repealed its mandate.[118] Two interrelated concerns spurred the decision—the law failed to reduce the nation's aggregate health care costs, and it was beginning to produce detrimental effects in local communities.

Shortly after CON was mandated to the states, the nation's aggregate health care costs reached an historic high. America's 1982 medical bill reached $332 billion, or 10.5 percent of the gross national product.[119] "This marked the first time the cost of medical services exceeded ten percent of the nation ['s total production."[120] "In one comparison of health care prices and expenses, it was shown that such prices and expenses are actually higher in areas with CON regulations than they are in areas without CON."[121] In fact, national hospital care expenditures increased from $52.4 billion when Congress enacted the 1974 National Health Act to an estimated $230.1 billion in 1989.[122] Today, Americans are spending nearly a trillion dollars annually on health care.[123] In searching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering health care costs.[124] CON "has elicited a remarkable evaluative consensus—that it does not work."[125]

CON, in addition to failing to decrease national health care expenses, was having detrimental effects on the provision of health care in local communities. The effect of CON on local communities was perhaps best related to Congress by the words of Representative Rowland of the Eighth District of Georgia. Representative Rowland recognized that CON appeared to be a good idea in theory, yet in reality failed to control health care costs and was often insensitive to community needs.[126] In Representative Rowland's district:

> [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.[127]

Putnam County protested the agency's decision.[128] The county's growth projections indicated that all fifty beds would eventually be needed, even though the hospital was not currently utilizing all of its

beds.[129] Likewise, Putnam County's cost estimations indicated that the decrease in beds would have no significant effect on health care costs.[130] The decrease in beds "would, however, reduce the number of nursing students who could be enrolled in the hospital's LPN program at a time when the country has a critical shortage of nurses. And it would be much more costly when the county has to add back those 10 beds."[131]

Nevertheless, the state CON agency would not acknowledge the long-term increase in cost caused by having "to add back those 10 beds," nor would the agency consider the long-term impact on the nation's shortage of nurses which could be exacerbated by eliminating Putnam County's ability to train licensed practicing nurses.[132] "Eliminating the beds would, however, enable the State health planning agency to get the number [of beds] more in line with . . . the [regional] quota . . . [I]t's a classic case of a [bureaucracy] paying more attention to numbers on a piece of paper than to reality."[133] The reality, according to Representative Rowland, was "the harmful impact this would have on the community without doing anything significant to cut costs."[134] Representative Rowland did not blame the bureaucrats for these ill effects, but rather blamed the CON laws that necessitated such bureaucracy:

> Although I believe the people at the State health planning agency are sincere, I also recognize they are tied to a system that is often high-handed and arrogant. Federal funding for certificate-of-need programs was ended in 1987, and 12 States have now abandoned the program altogether. It's now time to abolish it throughout the Nation. If anyone wants to know why, just ask the people of Putnam County.[135]

C. The Perseverance of Certificate of Need

After repealing the 1974 National Health Act and its CON requirements, Congress did not "abolish [CON] throughout the Nation"[136] as Representative Rowland urged. Congress only repealed the legislation mandating state CON laws.[137] States were free to continue regulating health care facilities with CON even after Congress repealed its mandate.[138] Many states did.[139]

One may question the wisdom of continuing any form of state regulation that failed to produce its desired goal when implemented nationwide.[140] As the review of Congress's intent indicates, CON had one goal—to save money. However, in those states which retained their CON laws, the retention was often supported by new and creative justifications, many of which were unrelated to saving money. Commentators, in their traditional role of explaining the reason behind events, have set forth many justifications explaining why states have kept the same old CON laws.[141] All these justifications, however, are the crafty work of commentators, and not the motivation of state legislatures. No state legislature has codified any of these new justifications as legislative intent.[142] These justifications should therefore carry little weight in a proper analysis.[143]

Even though CON perseveres, the rationale supporting CON has disappeared. The logic of CON was based on the health care marketplace as it existed in the 1950s through the early 1970s. Today's medical marketplace is significantly different. CON is predicated on a medical marketplace dominated by third party fee-for-service agreements. However, the modern medical marketplace is shifting away from fee-for-service. The institutions who are the primary purchasers of health care services are banding together with the aid of governments.[144]

III. ORIGIN AND INTENT OF THE MANAGED COMPETITION HEALTH CARE STRATEGY

A governmental system fostering alliances between health care purchasers in order to manipulate the price of health care suppliers is called a managed competition plan.[145] Under managed competition,

governments aid purchasers in negotiating the lowest price for health care.[146] However, the effectiveness of a group of purchasers is greatly lessened when they cannot negotiate against a single hospital, but rather must negotiate with a legalized cartel of hospitals, as is the result under a CON system. The following section suggests that managed competition is doomed to failure unless CON laws are repealed or dramatically scaled back.

Many states are now grappling with the dilemma of meshing the two health care strategies: managed competition and CON. Both strategies, it seems, foster the same goals, but differ in the means used to achieve these goals. Whereas CON attempts to control the marketplace by regulating supply, managed competition aspires to influence prices by putting purchasers on an equal playing field with their organized adversaries.

Like CON laws which evolved from philanthropic activities supported by special interest groups,[147] managed competition laws evolved from the ideas of academicians and were adopted by special interests.[148] Professor Alain Enthoven, of the Stanford University Graduate School of Business, first devised managed competition as an approach to health care reform in the late 1970s.[149] The Enthoven model was further refined by the Jackson Hole Group,[150] and has become the leading model for a managed competition health care delivery system.[151]

The managed competition strategy proposes a scheme of private insurance plans presenting individuals with a range of enrollment options offered by companies which manage the selection process and make individuals pay the difference in price among the insurance options chosen.[152] Legislation dictates what kinds of health plans will be available, therefore creating uniform health care products from which to choose. A separate government entity assumes the task of aggregating health care purchasers, and negotiates on their behalf with providers to purchase the necessary health care products at the lowest possible price.[153] "Managed competition attempts to achieve universal health insurance coverage and health care cost containment via a hybrid between the opposite extremes of a completely socialized system of health insurance like Canada's, and a largely unregulated private insurance market such as currently exists in the United States."[154] This "hybrid" intends to be an enhancement of the existing market system that will "preserve and improve the benefits of competition without sacrificing the social objective[s]."[155]

Managed competition, therefore, uses government regulators to ally health care purchasers in order to negotiate better prices from health care providers.[156] The classic structure of managed competition combines government action in the form of health boards[157] and health alliances[158] with private free-market activity in the form of private health plans.[159] The critical factor of managed competition is that market forces, and not regulatory forces, determine the cost of health care.[160] Government's role in the managed competition strategy is that of organizer and motivator.

A. Governmental Health Boards and Alliances

Through governmental health boards, regulators would set broad guidelines and enforcement standards [161] and stimulate collaboration among purchasers, patients, and the government.[162] Governmental health boards would achieve these goals by selecting the individual health plans offered to health care consumers.[163] In essence, the health board would set broad policy, and implement that policy by regulating the forms of health insurance available in the marketplace.[164]

Through health alliances, the government would attempt to empower the disadvantaged to become players in the free market for health care. Alliances "would have the authority to set global budgets, exclude health plans, and negotiate rates."[165] Alliances function by amassing the purchasing power of

a multitude of health care purchasers, and negotiating on their behalf in order to demand the lowest prices from providers.[166] A governmental health alliance's goal is to bring the purchasing power of larger businesses to the small business community and to individuals.[167]

B. Private Health Plans

Under managed competition, governmental health boards would approve insurance plans that "employ financial incentives and managed care techniques to deliver a more economical and efficient package of health care benefits."[168] Such plans would be offered by private insurance companies.[169] Examples of acceptable plans are the Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) offered by the leading health care insurers.[170]

An HMO is a type of managed care company that provides comprehensive health care coverage for a fixed price to a specific group.[171] HMOs negotiate discounted charges with health care providers, and restrict members to using only that network of providers.[172] HMOs typically refuse to pay for the medical bills of a member who does not use a network provider.[173] In this way, HMOs greatly reduce the consumer's cost of health care.[174]

A PPO is another type of managed care company, similar to an HMO, providing comprehensive health care coverage to a specific group.[175] The primary difference between an HMO and a PPO is that a PPO will allow members to see a doctor outside of its network of physicians, but will not pay so much of the cost as it would if the member saw one of the doctors in the network.[176] HMOs, PPOs, and their hybrid forms[177] can be referred to generally as managed care companies, all of which play a managerial role under a managed competition health care plan.[178]

Managed care and managed competition are not synonymous.[179] Managed competition refers to the overall market structure, including government involvement.[180] Managed care refers to a private association of health care providers who collectively bargain for the use of their services.[181] The collective services of such providers are referred to as integrated delivery systems.[182] These systems are more than vertical integration and joint ventures—they cover a broad range of services, including a full array of hospital and physician services in both inpatient and outpatient settings.[183] They may also include long-term care facilities and specialized services such as mental health or physical therapy.[184] The managed care company and integrated delivery systems are a new form of provider,[185] created in response to the difficulty of individual providers to prosper in the new health care marketplace.

Although managed competition appears promising, no hard evidence unequivocally proves that managed competition is effective.[186] "Managed competition is a controversial public policy that is still being debated, even as it is taking hold of the health care delivery system."[187] One United States Congressman has referred to managed competition as a "fairy tale," while another likened it to the "Star Wars" defense initiative.[188] Even the Congressional Budget Office declared managed competition to be "untried."[189] These concerns about the viability of managed competition are not ill-founded, considering the fact that no nation or state has yet fully implemented a managed competition system.[190] Even the Jackson Hole Group admits that managed competition proposals seem stymied by the inability to predict the economic consequences of their implementation.[191]

States are nonetheless wagering that managed competition will succeed,[192] and commentators are predicting that the proliferation of managed competition is inevitable.[193] The following question is therefore appropriate: what role should CON laws play in a managed competition state?

IV. WHY CERTIFICATE OF NEED IS NOT NEEDED UNDER MANAGED COMPETITION

Unfortunately, in states implementing CON, managed competition will fail. In the words of one commentator:

> [With the proliferation of] certificate-of-need laws . . . an unexpected consequence may follow—a severe restriction of competition in the health care market. [CON laws are] cost-containing only if the excluded providers would have relied on fee-for-service, cost-based, retrospective reimbursement. Prepaid medical group practices or Health Maintenance Organizations (HMOs), however, operate under entirely different rate structures and payment mechanisms . . . . [R]educing [the HMOs'] ability to enter the market or to expand may contribute to higher health care costs. Where certificate-of-need laws limit resources effectively, the owners of existing facilities are in a seller's market. They can charge inflated prices for their facilities, making it impossible for the HMO to develop or expand . . . . [C]ertificate-of-need laws will continue to raise health care costs by restricting the entry of cost-effective providers into the market.[194]

This commentator is illustrating a stark reality of managed competition—it can succeed only if health care providers are forced to negotiate lower consumer prices with health care alliances.[195] CON laws shelter health care providers from the price-cutting demands of health care alliances.[196] "Strength in numbers,"[197] the very reason why a managed competition health care strategy is touted to succeed, would be thwarted by hospital cartels united under CON laws. If HMOs and other managed care companies can be forced from the marketplace by united hospitals, then managed competition will fail.

Instead of risking the failure of the managed competition health care strategy, states should repeal CON laws.[198] Managed competition serves as a "nail in the coffin" of CON by making obsolete the rationale and reasons for CON.[199] Below, each of Congress's reasons for promoting CON is addressed, and shown to be moot under a managed competition health care strategy.

A. Managed Competition Market Incentives Can Adequately Restrain Health Care Costs

Congress's first reason for promoting CON was to address a perceived inability of the health care marketplace to adequately restrain health care costs.[200] However, a managed competition health care marketplace would keep a keen eye on health care spending. For example, many HMOs and managed care companies restrain health care costs by using the Health Plan Employer Data and Information Set (HEDIS).[201] HEDIS is used by HMOs as a performance measurement to give a numerical answer to questions about how well a given health plan serves its members.[202] Inefficient health plans are replaced by more efficient plans.[203]

As well as monitoring HEDIS, managed care companies also monitor "outcomes."[204] "Outcomes" are a measurement of the effectiveness of medical treatments, judged against factors such as mortality and cost.[205] By monitoring outcomes, managed care companies are creating a health care marketplace which seeks to restrain health care costs.

A third and vitally important feature of managed competition that makes the marketplace more responsive to health care costs is managed competition's abandonment of the third party fee-for-service system. Whereas fee-for-service involves individualized payments for each health care service,[206] managed care companies negotiate service discounts in exchange for sending patient volume to providers.[207] The result is the demise of traditional indemnity insurance, in which companies pay whatever rate a health care provider may ask.[208] Instead, health care providers receive a previously

arranged maximum fee for the service performed, and the health care consumer saves money.

Fourth and finally, managed competition gives government, in its role of health care board and health care alliance, the ability to stack the deck in favor of restraint on health care costs. Health care alliances will have the authority to set global budgets.[209] and thereby impose self-restraint on providers who realize that a finite amount of resources will be allocated to their reimbursement. A health care alliance which perceives health care costs to be increasing at too great a rate can thwart that trend by "tightening the money supply"[210] and decreasing the aggregate amount of revenue available to providers. Should a given delivery system[211] not respond to an alliance's global budget pressure or otherwise prove too costly, a health care board would have the authority to eliminate the delivery system from the options available to consumers.

B. Managed Competition Market Incentives Can Adequately Prevent the Unnecessary Duplication of Health Resources

Congress's second reason for promoting CON was that health care markets cannot adequately prevent the unnecessary duplication of health resources.[212] Yet, integrated delivery systems and managed care companies like HMOs have the ability to manage health care resources. "HMO development is perhaps the most promising nonregulatory strategy for bringing the excessive use of health care resources under effective control."[213]

Hospitals which are allied with HMOs and other managed care companies should be exempt from CON statutes.[214] Hospitals managed by managed care companies do not face the same incentives for overexpansion that characterize fee-for-service hospitals.[215] Managed care companies pay providers in advance, rather than retrospectively on a cost-reimbursement basis, and thus have "every incentive to conserve their resources and to seek efficiency."[216] Therefore, another presumption of CON—the marketplace's failure to control the unnecessary duplication of health care resources—is not valid under managed competition.

California, Oregon, and Washington have recognized that hospitals controlled by managed care companies should be exempt from CON regulations thwarting facility construction.[217] These states have taken an important and necessary first step toward the success of managed competition. By exempting managed care companies from CON laws, these states recognize that managed competition eliminates the four presumptions underlying the conclusion that the health care marketplace allows for the unnecessary duplication of health care resources.[218] In the following discussion, the four presumptions—the externalization of purchase costs,[219] the non-price competition between facilities,[220] the physician's effect on supply,[221] and the "Roemer Effect" on demand[222]—are demonstrated to be inapplicable in a managed competition system.

1. No Externalization of Purchase Costs

Proponents of CON contend that the health care marketplace results in an externalization of purchase costs because fee-for-service insurers will reimburse for any provided health service.[223] In other words, a patient need not worry about health care costs, because "insurance will cover it."[224] If this externalization of purchase costs was ever a reality,[225] it ceases to be so under a managed competition health care plan. Managed care companies and integrated delivery systems negotiate fees well in advance of service, and often base those fees on local averages obtained using diagnostic-related group formulas.[226] Diagnostic-related group formulas, or DRG formulas, are "classification[s] developed by Medicare a decade ago to determine how much the federal program will pay for inpatient care."[227] DRG formulas provide health care providers with a fixed payment for treating patients, regardless of the

provider's expense in providing the care.[228] Thus, under managed competition, purchase costs are not external, but rather internal.

The latest managed care proposal from the Jackson Hole Group, as well as internalizing purchase costs via managed care companies, further effects an internalization by requiring government to maintain a balanced health care budget.[229] The Jackson Hole Group notes that a managed competition state needs to achieve a predictable and acceptable level of health care spending, and proposes that the most effective method of achieving this goal is to require that health expenditures not grow faster than revenue.[230] As a result, governmental health alliances would be unlikely to pay more for the same services simply so that a provider can be repaid for unnecessary facilities or equipment. The actual use of the facility or equipment would have to pay for itself by attracting new patients or otherwise generating new revenue, because an alliance constrained by a balanced budget would not likely pay increased fees without gaining increased services in return.

2. Non-Price Competition Among Facilities Replaced by Price and Quality Competition

Proponents of CON contend that it is absolutely necessary to prevent non-price competition between health care providers.[231] Under managed competition, non-price competition is nearly eliminated by the use of "gatekeepers."[232] A gatekeeper is an entity employed by a managed care company to ensure that patients do not unnecessarily increase the cost of health care.[233] For example, a gatekeeper may require that a patient first see a primary care physician[234] before visiting a more expensive specialist[235] or seeking tertiary care.[236] All patients must first contact the managed care company's gatekeeper before seeking non-emergency treatment.[237] A patient is thereby precluded from visiting the biggest, most elaborate, most modern facilities when such facilities are not medically necessary.

Furthermore, managed competition fosters sharp price competition between health care providers. In fact, critics of managed competition note that health care providers in a managed competition environment can compete on few terms other than price.[238] The design of managed competition is singlemindedly structured to create price competition among health care providers.[239]

Quality competition would indirectly arise in managed competition under the guise of efficiency. Alliances and managed care companies, in measuring outcomes, would be searching for the highest return on their health care investment. Providers with poor outcomes would cause a patient to need more health care services, which in turn would increase the price paid to care for the patient. The increased price would be noticed, and the services of the provider necessarily avoided by alliances and managed care companies. As a result, although alliances and managed care companies might not specifically search for quality, their search for the best return on their health care dollar will result in a preference for quality care.

3. Counteracting the Physician's Effect on Supply

The physicians' effect on supply, a concern of CON proponents, is overcome in a managed competition state by the HMO's effect on supply.[240] HMOs counteract a physician's ability to order excessive or unnecessary medical treatment by implementing utilization review programs.[241] Utilization review requires a physician to seek prior approval from the HMO before commencing with non-emergency medical procedures, and allows a managed care company to "look back at the care rendered to check whether [the care] was appropriate."[242]

Managed competition also thwarts the physician's effect on supply via capitation. Capitation is "[a] method of reimbursement, typically used by health-maintenance organizations, in which health-care

providers receive a fixed payment for every patient regardless of how much care individual patients need."[243] Capitation provides financial disincentives for doctors and providers who would order too many tests or too many patient visits.[244] Therefore, even a doctor with a light schedule will not have the incentive to see his patients any more than medically necessary.[245]

Typically, utilization review and capitation are methods used by HMOs, but under managed competition, governmental health boards would have the authority to design and mandate the use of integrated delivery systems which incorporate utilization review and capitation.[246] Should a given delivery system prove too costly, the health board can redesign it to include utilization review and capitation. In short, managed competition arms the health care consumer with a powerful weapon to battle effectively a spendthrift physician.

4. Elimination of the "Roemer Effect" on Demand

A final component of the perceived need to control the unnecessary duplication of health resources results from the "Roemer Effect" view that the demand for medical services can be adversely controlled and manipulated by health care providers.[247] Under managed competition, health care providers are thwarted from generating demand for their services. Managed care companies require pre-admission certification before a physician can admit a patient to the hospital.[248] Thus, only medically necessary admissions will be made, as the hospital's incentive to fill beds is counterbalanced by the managed care company's desire to avoid paying for a filled bed.[249]

In addition, under a managed competition system with a balanced health care budget requirement, such as that suggested by the Jackson Hole Group, alliances would strongly resist any unnecessary cost.[250] If resistance is futile, governmental health boards can mandate the redesign of delivery systems to incorporate sufficient deterrents to the Roemer Effect.[251]

In sum, managed competition creates a health care marketplace where adequate incentives exist to prevent the unnecessary duplication of health care costs. Purchase costs are internalized. Competition is based on price and quality. Physicians have little or no effect on supply and the "Roemer Effect" no longer affects demand.

C. Achieving Equal Access to Quality Health Care at a Reasonable Cost

Managed competition also creates a health care marketplace with an excellent chance of achieving equal access to quality health care at a reasonable cost. CON laws state an intent to achieve equal access at reasonable cost, but rarely include any action to implement that intent.[252] The managed competition health care model includes a clear action plan to achieve equal access at reasonable cost. Via governmental alliances, the disadvantaged can share in the purchasing power of government agencies.[253] These alliances have the single goal of making private insurance more accessible and affordable to disadvantaged individuals through collective bargaining power.[254] No hard evidence has yet proven that alliances will succeed, but even an unproven plan such as that offered by managed competition is preferable to the failed plan offered by CON.

V. A CASE STUDY: HOW FLORIDA'S CERTIFICATE OF NEED LAWS OPERATE AND CONFLICT WITH MANAGED COMPETITION HEALTH CARE REFORM

Florida provides a prime example of the conflict between CON and managed competition.[255] In order to illustrate best the conflict, the following discussion presents Florida's CON laws and Florida's interpretation of managed competition.[256] The discussion then identifies the Legislature's

acknowledgement of the conflict between CON and managed competition.[257]

The origin of CON in Florida parallels other states' similar laws, originating from local community efforts to allocate philanthropic and federal funding.[258] Florida's first CON laws were part of the Health Facilities and Health Services Planning Act, passed just one year before the effective date of the Congressional mandate.[259]

A. How the Certificate of Need Program Operates in Florida Today: The Statutes and Rules

Florida's current CON statutes are known as the "Health Facility and Services Development Act."[260] The statutes are supplemented by agency-promulgated administrative codes.[261] The structure of the statutes and rules still shows the influence of the 1974 National Health Act.[262]

Under Florida law, anyone operating a hospital, nursing home, or intermediate care facility without first obtaining a CON is guilty of a second degree misdemeanor.[263] Additionally, anyone operating without a necessary CON can be fined up to $5,000 for every day the facility operates without the certificate.[264] Thus, Florida health care facilities are very aware of CON laws.

1. Determining Whether a Given Project Requires a Certificate of Need

Before breaking ground for construction, offering a new service, or purchasing medical equipment, a Florida health care facility should first determine whether the new project or purchase will require a CON.[265] Certain projects are exempted from CON review.[266] To determine whether a project or purchase is exempt, the safest and most cost-effective method is to file a request for exemption[267] with Florida's Agency for Health Care Administration (AHCA or Agency).[268]

2. Securing a Certificate of Need

Projects requiring a CON in Florida include, but are not limited to, new construction,[269] capital expenditures beyond a specified limit,[270] conversion of one type of health care facility to another,[271] changes in licensed bed capacity,[272] establishment of a home health agency or hospice,[273] establishment of inpatient institutional health services,[274] acquisition of a facility,[275] acquisition of major medical equipment,[276] exceeding the approved budget when constructing a facility,[277] establishment of tertiary health services,[278] and a change in the number of psychiatric or rehabilitation beds.[279] In order to obtain a CON, the applicant must follow the administrative rules promulgated by the Agency and involving local health councils.[280]

a. Step One: Letter of Intent

The first step to securing a necessary CON is to file a letter of intent with the Agency and with the local health council for the area in which the project will be located.[281] "The letter of intent process has become the major hurdle for an applicant to overcome . . . ."[282] The letter of intent must include the legal name, mailing address, and telephone number of the applicant,[283] a specific description of the project,[284] proposed capital expenditures,[285] the number of beds sought,[286] services to be provided,[287] type of equipment and method of acquiring that equipment,[288] subdistrict location to be served,[289] and a certified copy of a resolution of the applicant's Board of Directors authorizing the project.[290] No CON can be issued to an applicant that does not properly file an adequate letter of intent.[291] Even if the letter of intent appears proper and passes initial scrutiny, a flawed letter of intent can cause a winning applicant to lose his CON if challenged in an administrative proceeding.

b. Step Two: Filing of the CON Application

After properly filing a letter of intent, a CON application may be submitted. The CON application must be filed with the Agency and the local health council by the batching cycle deadline and must be submitted in the proper form.[292] The required contents for the CON application are enumerated by statute and rule.[293] The practitioner should review successful CON applications before drafting his own.[294] The wise practitioner also includes "letters, testimonials, resolutions, and similar documents to bolster the presentation of [his] case."[295]

If the Agency determines that the proposed project involves issues of great public importance, then the Agency may hold a public hearing.[296] Otherwise, the Agency has sixty days[297] to issue a State Agency Action Report (SAAR) and Notice of Intent which will either grant the CON in its entirety, grant a CON for a specific portion of the project, or deny the CON.[298] The Agency must publish its proposed decision in the Florida Administrative Weekly within fourteen days after issuing the SAAR and Notice of Intent.[299] Any "substantially affected person,"[300] within twenty-one days after publication, may request an administrative hearing by filing a petition with the Agency[301] and serving a copy of the petition on the successful applicant.[302] Any applicant denied a certificate of need in the same batching cycle has a right to an administrative hearing if requested within twenty-one days of the Agency's publication of its decision.[303] Hearings are held in Tallahassee, Florida unless a change in venue will facilitate the proceedings.[304]

B. Florida's Managed Competition Laws

As the preceeding discussion illustrates, Florida's CON laws are typical of those found in most states. Florida is atypical, however, in its commitment to adopt a managed competition health care strategy. Today in Florida, managed competition is slowly becoming a reality. In 1993, Florida's legislature responded to the plight of 2.5 million uninsured Floridians[305] by making Florida the first state to adopt a managed competition health care strategy.[306] The enacting law is dubbed the "Health Care and Insurance Reform Act of 1993."[307] In order to understand how certificate of need laws will conflict with Florida's managed competition plan, a summary of Florida's managed competition system is presented.[308]

1. Managed Competition As Implemented in Florida

> It is the intent of the [Florida] Legislature that a structured health care competition model, known as "managed competition," be implemented . . . . The managed competition model will promote the pooling of purchaser and consumer buying power; ensure informed cost-conscious consumer choice of managed care plans; reward providers for high-quality, economical care; increase access to care for uninsured persons; and control the rate of health inflation in health care costs.[309]

This preamble to Florida's Health Care and Insurance Reform Act of 1993 is the guiding intent for Florida's Agency for Health Care Administration, which is charged with implementing the rules and regulations to create a managed competition health care marketplace in Florida.[310] The Agency calls Florida's new health care strategy "a voluntary, market-based managed competition model."[311]

a. Florida's Health Boards and Alliances

In the Florida model, Accountable Health Partnerships, or AHPs,[312] will perform the role of governmental alliances,[313] and Community Health Care Purchasing Alliances, or CHPAs,[314] will

perform the role of governmental health boards.[315] An AHP is defined as "an organization that integrates health care providers and facilities and assumes risk, in order to provide health care services."[316] A CHPA is defined as a "state-chartered, nonprofit organization that provides member-purchasing services and detailed information to its members on comparative prices, usage, outcomes, quality, and enrollee satisfaction with [AHPs]."[317]

A CHPA, therefore, is a group purchasing mechanism.[318] An AHP is the entity that actually delivers health services to CHPA members.[319] AHPs may be created by health care providers, HMOs, or health insurers, so long as licensing and competency requirements are met.[320] CHPA membership is voluntary,[321] but all CHPA members must purchase their health care services from an approved AHP.

Florida's AHPs are required to use managed care procedures for containing costs, including utilization management,[322] HEDIS-style monitoring,[323] and monitoring of access,[324] grievances,[325] and outcomes.[326] AHPs must contract in advance with providers in order to obtain health care services at the lowest price, because only the AHP with the lowest, adequate response to a CHPAs request for proposal will be awarded the right to provide health care to individuals residing in the AHP's geographical area.[327]

b. Florida's Managed Competition Private Health Plans

Various managed care companies will perform the role of private health plans,[328] including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Exclusive Provider Organizations (EPOs), and point-of-service plans.[329] Florida will also offer "pure indemnity plans," which are the equivalent of third party fee-for-service insurance plans.[330]

c. Rough Beginnings: The Difficulty in Implementation, the Likelihood of Failure, and the Questionable Constitutionality of Florida's Managed Competition

Implementing managed competition in Florida is proving to be a slow process. During the 1994 legislative session, only one managed care bill became law.[331] Likewise, the 1995 regular session passed only one managed care bill, and the passage of additional managed care bills in a special session appears doubtful.

Some predict that Florida's managed competition, as currently being implemented, is doomed to failure.[332] The characteristic cited by those who predict failure is that Florida will not require small employers to purchase coverage through the CHPAs and will not require that employers or individuals purchase health insurance.[333] Due to this characteristic, Florida's CHPAs "cannot bear any risk or make adjustments to compensate for risk between plans."[334]

The Legislature, as well as finding difficulty in passing managed competition laws, may also encounter difficulty in drafting managed competition laws that withstand constitutional attack. In *Albertson's, Inc. v. Department of Professional Regulation*,[335] the District Court of Appeal affirmed the trial court's determination that part of the Florida Health Care and Insurance Reform Act of 1993 violates the Commerce Clause of the United States Constitution.[336] The unconstitutional provision[337] of the Act involved the legislation's attempt to allow Florida small business pharmacies, or "independent" pharmacies, to sell prescriptions to CHPA members even though the "independent" pharmacies were not affiliated with an approved AHP.[338] This "independent" exception was intended to benefit only the smallest of small businesses, and therefore did not apply to businesses owning more than twelve Florida pharmacies or owning any non-Florida pharmacies.[339] The exclusion of non-Florida pharmacies was found on its face to place an impermissible burden on interstate commerce, but the exclusion of

businesses owning more than twelve Florida pharmacies was facially upheld.[340]

Albertson's illustrates the difficulty of implementing managed competition on a state rather than national level. Managed competition attempts to lower health care costs by affecting who enters the marketplace and on what terms.[341] State managed competition laws will therefore inevitably have a substantial effect on interstate commerce. *Albertson's* is an elementary case foreshadowing more difficult cases in which state managed competition laws will be alleged to be unconstitutional as applied to a given plaintiff. In those future cases, a state's managed competition law will survive only if the law is narrowly drawn to cause only an incidental effect on interstate commerce.[342] The theory of managed competition, however, is not narrowly drawn. The more areas of commerce that managed competition can affect, the more effective managed competition becomes. *Albertson's* suggests that, although state legislatures can proceed far down the path toward managed competition, federal legislation may ultimately be needed in order to enact completely the managed competition system.

2. Florida's Certificate of Need Statutes Cannot Co-Exist with Managed Competition

The Florida Legislature faces delays and problems in implementing managed competition, but has nevertheless succeeded in implementing more managed competition reform than any other state legislature.[343] However, gravely looming on Florida's horizon is the problem of managed competition's conflict with Florida's CON laws. As Florida's Agency for Health Care Administration grudgingly acknowledges, the goals of managed competition in Florida are indistinguishable from the goals of CON:

> It was not until 1993, however, when the Legislature passed the Health Care and Insurance Reform Act that a major issue about the continuation of the CON program emerged. The managed competition model adopted by the 1993 Legislature is intended to accomplish many of the same objectives as the CON program.[344]

The Agency is correct in stating that Florida's managed competition model is intended to accomplish the same goals as CON. For example, managed competition is designed to "control the rate of inflation in health care costs,"[345] while CON is designed to "[e]valuate the availability of more cost-effective service alternatives" and "[p]revent unnecessary hospital capital expenditures."[346] Managed competition will "reward providers for high-quality, economical care,"[347] while CON will "[s]elect providers with a proven quality of care record."[348] Managed competition should "increase access to care for uninsured persons,"[349] while CON should "[p]rovide access by predicating CON approval on serving indigent and other underserved persons."[350] Florida's managed competition laws, therefore, will be designed to achieve the same goals as Florida's CON laws. The only difference will be in the means to the end,[351] and, as history has proven, the means chosen by CON laws are ineffective.[352]

a. Florida has No Need for Certificates of Need Under Managed Competition

The Florida Legislature must do more than merely note the Agency's acknowledgment that CON and managed competition have the same goals. The Legislature must recognize that CON is unnecessary under managed competition, and that the reasons and rationale justifying CON no longer exist.[353]

CHPAs create market incentives to restrain health care costs adequately by acting as powerful purchasers who have the market clout to demand lower prices. CHPAs can achieve this effect by choosing AHPs via requests for proposals.[354] The request for proposal is a formal method for soliciting bids from AHPs which contain detailed financial and service statements and allow CHPAs to evaluate AHPs on equal terms.[355] To win a bid, an AHP must cut costs at every possible level, while

a committee substitute[371] which only "removes certain health care projects from the certificate-of-need review requirements . . . ."[372] Even this bill was replaced by a second committee substitute[373] that only "modifies certain licensure requirements applicable to hospitals and ambulatory surgical centers . . . ."[374] The final bill that passed the Committee made no mention of repealing CON.[375] On May 11, 1995, the bill died in the Ways and Means Committee.

The Senator or Representative who next proposes to repeal CON will evidently face an uphill battle. However, as CON begins to affect managed competition reforms adversely, the uphill battle may eventually be won.

VI. CONCLUSION

CON laws evolved from the health care reforms of the 1940s and were heavily promoted well into the 1970s by health care providers, who found CON effective in sheltering their businesses from the costly effects of a competitive marketplace. Congress mandated CON in 1974, but quickly repealed the mandate when CON failed to lower the nation's health care costs. Nevertheless, CON persists in thirty-eight states, including Florida. These states are finding that the reasons and rationale justifying CON no longer exist under managed competition health care strategy. Managed competition creates market incentives to restrain health care costs adequately by promoting a managerial role for managed care companies. Managed competition creates adequate incentives to prevent the unnecessary duplication of health care costs because purchase costs are internalized, competition is based on price and quality, physicians have little or no effect on supply, and the "Roemer Effect" no longer affects demand. Managed competition even fosters equal access to health care at a reasonable cost by providing governmental alliances with the power to negotiate on behalf of the disadvantaged.

CON has historically failed to control health care costs, yet the new managed competition model is likely to succeed. However, the perpetuation of CON threatens the success of managed competition. States should therefore repeal their outdated CON laws when implementing the managed competition health care strategy. Out with the old health care reforms; in with the new.

---

[*] The author thanks Mr. Dubose Ausley, whose financial support helped make this research possible. This Comment is dedicated to Joan McGinley, Alice Reynolds, and John Reynolds, the best friends a son and nephew could have. Return to text.

[1] Clark C. Havighurst, *Contract Failure in the Market for Health Services*, 29 WAKE FOREST L. REV. 47, 47 (1994) [hereinafter Havighurst, *Contract Failure in Health Care*]. Return to text.

[2] Commentators identify a definite trend toward the adoption of the managed competition health care strategy:

> Managed competition is the theory underlying not only President Clinton's health care reform proposal, but also the leading alternative plans proposed by conservative Democrats and moderate Republicans. Additionally, managed competition is being pursued in many states and by many private employers, and has been advanced as the fundamental basis for health care reform by private interest groups as diverse as hospitals, doctors, labor unions, and businesses. Therefore, it is no longer necessary to speculate whether managed competition in some form will be adopted.

The Other Sides Argument:

Why CON laws should be upheld

Eliminating the Certificate of Need requirements would increase health care costs.

Rebuttal: Since the 1980's when states were set free from the federal requirements to have CON laws, numerous studies have examined the change in health care costs as states eliminated their laws. *If CON laws were "working" as advertised, then one would expect to see a rise in health care costs in states where laws were eliminated. But in fact this is not the case. One of the most widely referenced studies was written by Duke University Professors Christopher Conover and Frank Sloan and published in the *Journal of Health Politics, Policy, and Law*. They found that output restrictions which resulted from CON laws led to higher not lower costs, and higher profits for existing providers (hospitals). The authors point out that CON laws resulted in higher costs per day and per admission in states with CON regulations, along with higher hospital profits. So, in states where CON laws remained, patients were charged more money, more often than in states that repealed the law. Simply put, the result of repealing CON regulations is lower health care costs for the people of that state. It's just as wrong-headed to think that limiting the supply of health care facilities can reduce health care costs, as it would be to think that oil prices could be brought down with further reductions in oil production.

If Alaska's CON regulations are repealed, the hospitals will no longer be able to provide care to the indigent or poor.

Rebuttal: The argument here is that entry restrictions, and the higher prices and profits that go along with them, are necessary to induce providers to provide free indigent care. So let me get this straight…the cost of health care and the profits to hospitals are purposely kept high by granting monopoly privileges. It is then expected that these excess profits will be used to provide free health care to the indigent. So health care customers are forced to pay a premium created by CON laws and the proceeds from this premium are used to pay for indigent care. This directly contradicts any "cost-savings" argument made by supporters of CON. If patients are paying a higher price in order encourage indigent care, then CON regulations are driving prices up, not down. Additionally, the State's use of non-medical criteria in deciding whether to approve a Certificate of Need (like an applicant's record of providing charity care) is evidence that the process has become arcane and politicized. Finally, the "free" indigent care the hospitals are providing is actually being paid for by the government in the form of huge subsides granted to them for such care. If the care is paid for by the state, why are we really charging patients a premium?

Repealing the Certificate of Need laws in Alaska would lead to the development of ASC's which are cited as a major cause of Hospital closures across the country.

Rebuttal: From 1987 – 1994, a period that saw more than a doubling of the number of ASC's in this country, the number of Hospital closures declined. Numerous other factors however, have been cited for hospital closures including:

a) Hospital mergers and acquisitions leading to large scale market consolidation during the 1990's
b) Failure to adjust to managed care and large reductions in average length of stay
c) The excess bed capacity of hospitals during the shift from inpatient to outpatient care.

State Commission on the Efficacy of the Certificate of Need Program and its Effect on Cost, Quality, and Access in Georgia; 08/08/2005

Free Market competition can't work as a means of cost-control in the health care industry.

Rebuttal: The idea that in the area of health care services free market competition can't work as a means of cost control is not grounded in either economic theory or empirical evidence. Competition is widely considered by economists as *the* most effective tool for driving down costs, something Alaska desperately needs. In areas where competition is allowed to flourish, the customer is well served with plenty of options and competitive pricing. Further, it is competition that provides the incentives to discover new technologies and new efficiencies for delivering those technologies to patients. Lastly, believing that CON laws and the bureaucrats that administer them can do a better job at containing costs than the competitive market process is not only wishful thinking, it's the economic equivalent to believing the earth is flat. Everyday experience shows that when the market is free to operate under minimal government oversight, the result is abundant, quality service and low price.

Repealing CON regulations would lead to duplication of facilities and services.

Rebuttal: Facility duplication is at the heart of competition. Indeed, the definition of a monopoly market is one where there is no duplication. And this is why customers in monopoly markets lose; they are denied the option of turning to others who are providing "duplicated" services when monopoly providers act like monopolists.

WASHINGTON POLICY CENTER

John Barnes, Policy Analyst
jbarnes@washingtonpolicy.org

Concerns regarding the fiscal note for Alaska's HB 287 (2006)

Scaling Down Certificate of Need Requirements

- Too little explanation of the fiscal note estimates. How *exactly* did they arrive at these numbers? This is especially important if the crux of the argument against scaling down CON laws is the fiscal impact on the state.

- The department predicts $2.7 million in expenditures for Cardiac Hospitals starting in FY2010, but admits there have not been any specific inquiries for such facilities.

- The department admits uncertainty with the numbers for various reasons, but insists their estimates are "conservative." This does not make sense. If this is true uncertainty, then their estimates could be high as well.

- In general, the department makes estimates and projections for several years down the road. You cannot assume this to be accurate. Financial estimates for that far out are laden with problems because of shifting variables and unpredictable circumstances. The general unreliability of state projections and projection methodologies is a large reason why CON laws do not help control health care costs. You cannot centrally-plan for the present or the near future, much less 6 or 7 years down the road.

- The department makes a $2.7 million projection for Orthopedic Hospitals without providing demonstration of interest. They state simply that "it is only a matter of time before they move to Alaska," and make a projection for FY2012. Fiscal notes ought not be based on the *supposed* inevitability of anything, and a projection for 6 or 7 years down the road is informed speculation at best due to shifting economic and demographic factors.

- In general, the calculation methodology (that which can be seen, at any rate) is suspect. The department is basing its estimation of facilities that would be built in a post-CON era on letters of intent and applications received in the past. But letters and applications are filed with the understanding that CON may not be granted. They are filed in an attempt to enter a market where providers are insulated from competition, where success is much more assured. When there is no CON barrier, providers have to be more careful in deciding to enter the market, and some who filed letters and applications would not actually proceed with projects because the likelihood for success changed. **You cannot assume that the number of letters and applications reflect the likely number of new facilities**.

- The fiscal note is based on the *assumption* that a massive supply surge will follow a CON downscaling. That is not necessarily true. A 1998 empirical study published in *Journal of Health Politics, Policy, and Law* examined health spending between the late 1970s and 1993

and found that in states that repealed CON laws, there was no surge in health spending.[1] This evidence contradicts the fiscal note's projections. [If this surge does occur, it will reflect the fact that the supply was abnormally depressed due to CON in the first place. In the long run Alaska will experience a leveling off of supply that reflects true demand.]

- A 2003 study by three leading authorities in the field of health policy found that aggregate state-level data from 1981 through 1998 shows states that repealed their CON and moratorium laws had no significant growth in either nursing home or long-term care Medicaid expenditures.[2] This evidence contradicts the fiscal note's projections, and *even if these facilities are not included in the bill, this evidence calls into question the department's methodology for fiscal impact and its assumptions in general.*

- Fiscal note numbers do not reflect the potential for cost reduction in the aftermath of CON downscaling. CON laws curtail services and facilities, often forcing patients into more expensive substitutes, thus increasing costs for patients or third-party payers. EXAMPLE: if nursing home beds are not available, the discharge of patients from more expensive hospital beds may be delayed or patients may be forced to use a more expensive nursing home.

- Fiscal note numbers do not take into account the potential for savings through reduced administrative costs, less personnel time, etc. If less time and resources are being spent running CON, that's money saved. This is true for business as well. Many businesses have entire departments devoted to just the CON process.

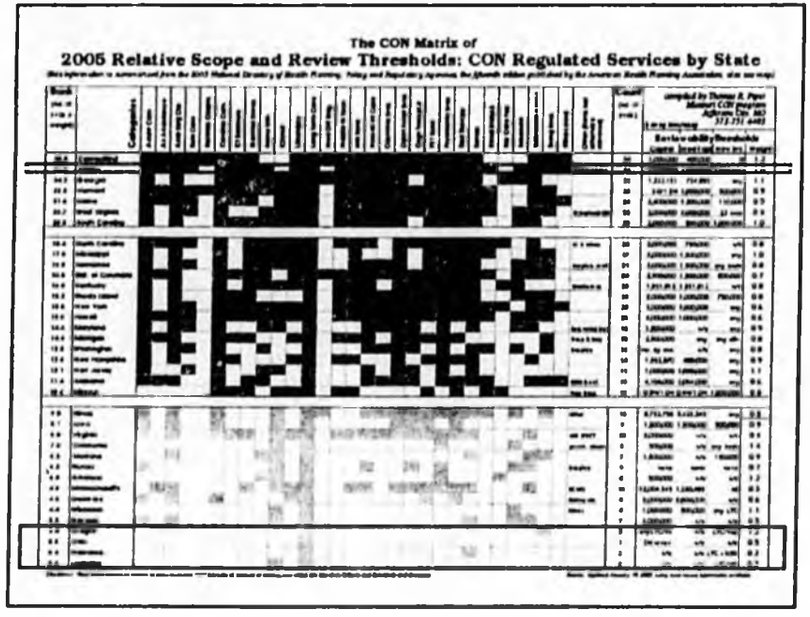
[1] Christopher Conover and Frank Sloan. "Does removing certificate-of-need regulations lead to a surge in health care spending?" *Journal of Health Politics, Policy, and Law*, Vol. 23, Issue 3.

[2] David C. Grabowski, Robert L. Ohsfeldt, and Michael A. Morrisey. "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures," *Inquiry* 40 (Summer 2003): 146-157.

National CON Perspective and Experience
Impact Report of Deregulation

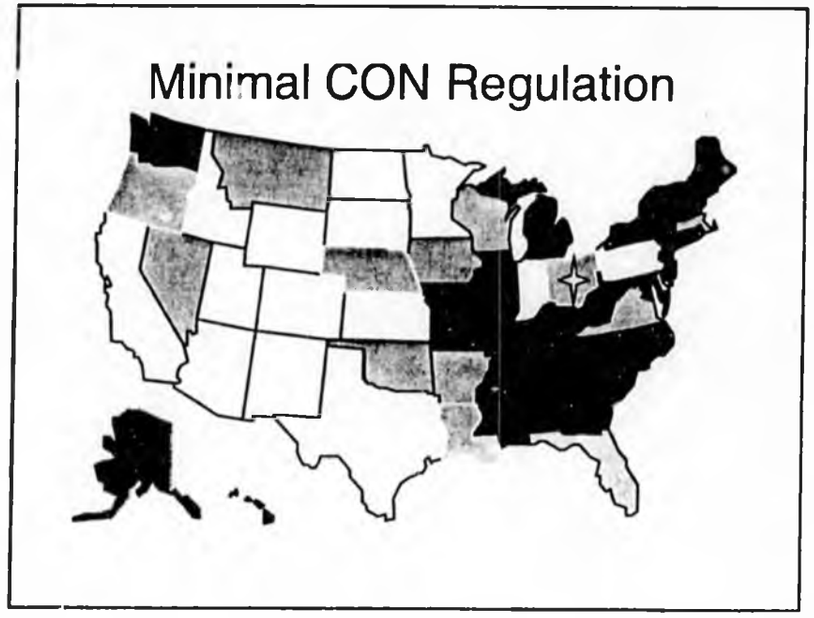
Thomas R. Piper
Principal, MacQuest Consulting

a presentation to the
Alaska House Health, Education, and Social Services Committee
at the March 28, 2006, hearing related to House Bill 287



The CON Matrix of

2005 Relative Scope and Review Thresholds: CON Regulated Services by State



Ohio General Assembly **repealed** CON in 1995

- 20-year duration
- All facilities
- Services
- Beds
- Capital
- Equipment
- (except long term care)

authored by ***Gretchen McBeath****, JD, Bricker & Eckler Law*

Phase Out 1995-1998

• Solid organ transplantation	March 1, 1998
• Bone marrow programs	March 1, 1998
• Cardiac catheterization	March 1, 1998
• Open heart surgery	March 1, 1998
• New hospitals	May 1, 1997
• Freestanding dialysis centers	May 1, 1996 (MSA); May 1, 1997 (rural)
• Hospital-based dialysis	May 1, 1995
• Ambulatory surgery facilities	May 1, 1996 (MSA); May 1, 1997 (rural)
• Freestanding/mobile MRI	May 1, 1996 (MSA); May 1, 1997 (rural)
• Hospital-based MRI	May 1, 1995
• Capital improvements	May 1, 1995
• Low risk OB/newborn	May 1, 1995
• High risk OB/newborn	March 1, 1998
• Hospital beds	May 1, 1995
• Linear accelerators	March 1, 1998
• Gamma knives	March 1, 1998
• Other equipment	May 1, 1995

No Hospital Licensure-
Quality Review instead

- cardiac catheterization
- open heart surgery
- obstetrics and newborn
- radiation therapy
- pediatric iCU units
- solid organ transplantation services
- bone marrow and
- stem cell transplant programs
- psychiatric and obstetric/newborn units (exception)

Free-Standing Services are Licensed

- Ambulatory surgery facilities
- Diagnostic imaging
- Dialysis
- Others

Ohio Hospitals Closed since Deregulation

	Before Deregulation		December 2000	
	# Hospitals	Beds	# Hospitals	Beds
Urban hospitals	62	25,091	56	20,994
Community hospitals	76	16,019	71	15,420
Rural hospitals	52	4,240	46	3,929
Psych/alcohol/rehab	24	1,239	18	1,035
Hospitals within a hosp	0	0	15	528
Total	**214**	**46,589**	**206**	**41,906**

Detail of Hospitals Opened since Deregulation

Type of Hospital	Number*	Number of Beds
Urban/cardiac**	2	71
Mid-size community	1	206
Rural	1	24
Hospitals within a hospital	15	528
Total	**19**	**829**

**two more in planning*

***two inner-city moved to suburbs*

Hospital Bed Decline since Deregulation

Type of bed	Before deregulation	December 2000
Special care	3,284	3,097
Med/surg	31,331	27,256
Obstetrics	2,715	2,462
Pediatric	2,808	2,649
Psychiatric	3,610	3,266
Rehab	1,618	1,790
Alcohol	1,530	928
Burn	111	103
Total	**47,007**	**41,551**

Cardiac Cath Increase since Deregulation

	Before Dereg	After Dereg
Number of Ohio hospitals*	190	173
Hospitals with cardiac cath	86 (42%)	94 (54%)
Hospitals with open heart surgery	38 (20%)	50 (29%)

**Ohio law allows these services in hospitals only*

Diagnostic Imaging Increase since Deregulation

	1995	1999
Non-hospital-based Mobile or free-standing MRIs	23	126*
Hospital with in-house MRIs	35	almost all

**Notices of Intent filed for 65 more since then*

Radiation Therapy Increase since Deregulation

	1998	1999
Non-hospital-based free-standing radiation therapy	10	28*
Hospitals with radiation therapy	?	2 added

**Notices of Intent filed for 6 more since then*

Ambulatory Surgery Facility Increase since Deregulation

	1995	2001
Ambulatory surgery facilities	31	186*

(many new ASFs are physician owned and operated**)

about 30 are eye-surgery-only facilities

***hidden effect in small communities: joint-ventures and hosp/phys adversity*

Outpatient Dialysis Increase since Deregulation

	1995	2001
Outpatient dialysis stations	1,053*	2,100+

(1) additions to existing dialysis programs in hospitals and freestanding facilities;
(2) new hospital-based dialysis programs; and
(3) new freestanding facilities

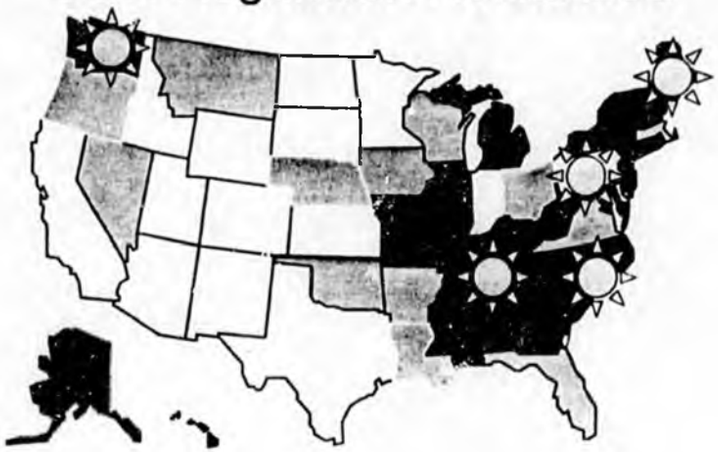
original projections that 40 more needed

Main Characteristics of Deregulation in Ohio

- a significant loss of inner city hospitals
- a substantial increase in ambulatory surgery facilities and other freestanding facilities
- hospitals have become more competitive.

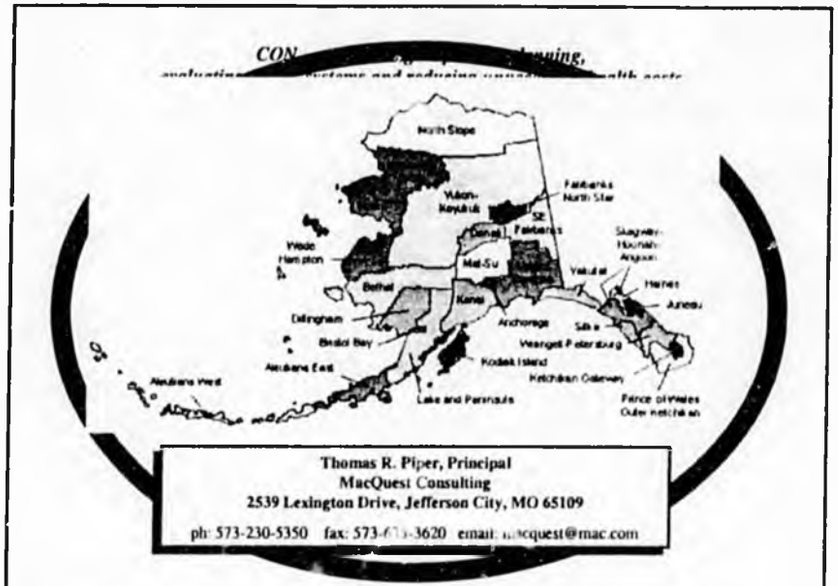
No useable statistics on capital expenditures have been available since deregulation.

CON Regulation Revitalized



Balance Regulation and Competition: Protect Community Interests

- Promote the development of community-oriented health services and facility plans
- Provide pricing and quality information to consumers so that they have an educated choice
- Provide a public forum to ensure that the community has a voice in health care



Thomas R. Piper, Principal
MacQuest Consulting
2539 Lexington Drive, Jefferson City, MO 65109
ph: 573-230-5350 fax: 573-[illegible]-3620 email: [illegible]quest@mac.com

Status Report on Ohio After Deregulation from Certificate of Need

Authored by Gretchen McBeath, Bricker & Eckler LLP
Presented by Thomas R. Piper, MacQuest Consulting
Alaska House Health, Education, and Social Services Committee
at the March 28, 2006 hearing related to House Bill 287

In 1995 the Ohio General Assembly repealed Ohio's twenty year certificate of need program for all facilities, services, beds, capital, and equipment, except for long term care facilities which remain indefinitely subject to certificate of need review. This article examines the situation in Ohio after deregulation and the information is current through September 2001 (no info tracked thereafter).

Deregulation Schedule

Ohio phased out its certificate of need program during a period starting in May 1995 and concluding March 1, 1998. Currently, everything in Ohio is deregulated and no longer subject to CON except for long-term care services. All activities associated with the long-term care industry, both freestanding and hospital-based, continue under certificate of need indefinitely. The Ohio phase-out took place according to the following schedule:

Solid organ transplantation	March 1, 1998
Bone marrow programs	March 1, 1998
Cardiac catheterization	March 1, 1998
Open heart surgery	March 1, 1998
New hospitals	May 1, 1997
Freestanding dialysis centers	May 1, 1996 (MSA); May 1, 1997 (rural)
Hospital-based dialysis	May 1, 1995
Ambulatory surgery facilities	May 1, 1996 (MSA); May 1, 1997 (rural)
Freestanding/mobile MRI	May 1, 1996 (MSA); May 1, 1997 (rural)
Hospital-based MRI	May 1, 1995
Capital improvements	May 1, 1995
Low risk OB/newborn	May 1, 1995
High risk OB/newborn	March 1, 1998
Hospital beds	May 1, 1995
Linear accelerators	March 1, 1998
Gamma knives	March 1, 1998
Other equipment	May 1, 1995

Ohio does not have a hospital licensure program but individual services are subject to quality review, similar to a licensure program. These services include

cardiac catheterization, open heart surgery, obstetrics and newborn, radiation therapy, pediatric ICU units, solid organ transplantation services, bone marrow and stem cell transplant programs. In addition, psychiatric units and obstetric/newborn units are subject to licensure. Most freestanding facilities such as ASFs, diagnostic imaging, dialysis are licensed. These licensure and quality review programs have not been a barrier to entrants seeking to establish new facilities and services.

Hospitals

New hospitals in Ohio have been deregulated since May, 1997. Although there have been some new hospitals built in Ohio, and a few more on the drawing board, the bigger story is the number of hospitals that have closed since deregulation.

	Before Deregulation		December 2000	
	# Hospitals	Beds	# Hospitals	Beds
Urban hospitals	62	25.091	56	20,994
Community hospitals	76	16,019	71	15,420
Rural hospitals	52	4,240	46	3,929
Psych/alcohol/rehab hospitals	24	1,239	18	1,035
Hospitals within a hospital	0	0	15	528
Total	214	46,589	206	41,906

The closure situation has been most dramatic in the inner cities where 9 long-standing large hospitals have closed. The breakdown of the closures and openings is as follows:

Hospitals Closed Since Deregulation

Type of Hospital	Number	Number of Beds
Urban/general	11	3,602
Mid-size community	6	1,001
Rural	4	265
Psychiatric/alcohol	6	538
Total	27	5,406

Hospitals Opened Since Deregulation

Type of Hospital	Number	Number of Beds
Urban/cardiac	2	71
Mid-size community	1	206
Rural	1	24
Hospitals within a hospital	15	528
Total	19	829

There are at least two additional hospitals either planned or actually under construction. One is a full-service hospital in Toledo and the other is a cardiac

hospital in Columbus. The Toledo hospital will have 70 beds and plans to open in November 2001.

It is significant that at least two of the large inner city hospitals that have closed were closed at a result of movement to the suburbs. In these cases, the inner city hospital acquired a small suburban hospital, expanded it, transferred the tertiary services from the inner city facility and then closed the inner city facility. This is obviously an attempt to capture more of the affluent suburban market that is currently not coming to the old inner city hospitals.

Hospital Beds

Ohio has experienced a decline in the number of hospital beds since the 1995 deregulation from certificate of need. As shown below, total hospital beds at the end of 2000 had decreased by 5,456. Most of this decrease is a direct result of the closures of the large urban hospitals discussed above.

Type of bed	Before deregulation	December 2000
Special care	3,284	3,097
Med/surg	31,331	27,256
Obstetrics	2,715	2,462
Pediatric	2,808	2,649
Psychiatric	3,610	3,266
Rehab	1,618	1,790
Alcohol	1,530	928
Burn	111	103
Total	47,007	41,551

***NOTE: The total bed numbers shown at the end of December 2000 here and the closures and openings of beds (above) do not precisely match due to the different time periods from which the two sets of numbers were derived. Also, bed numbers in both listings exclude nursery beds and SNF beds.**

Cardiac Services

Cardiac catheterization and open heart surgery were deregulated effective March 1, 1998. Ohio law currently prohibits cath labs and open heart surgery unless performed in a hospital. As of September 2001, the following statistics apply to cardiac services.

	Before deregulation	After deregulation
Number of Ohio hospitals*	190	173
Hospitals with cardiac cath	86 (42%)	94 (54%)
Hospitals with open heart surgery	38 (20%)	50 (29%)

***Includes only hospitals with medical/surgical capabilities and excludes psychiatric and other specialty hospitals**

Imaging

MRI's located in an existing hospital were deregulated as of May, 1995. Freestanding diagnostic imaging centers (a center which includes either an MRI or a CT scanner or both) were deregulated in MSA areas as of May 1, 1996 and in rural areas as of May 1, 1997. Immediately before deregulation, the Department of Health recognized 23 non-hospital-based mobile or freestanding MRI's in Ohio. As of July 1999, the Department listed 126 non-hospital-based mobile or freestanding MRI's. Since July 1999, another 65 notices of intent have been filed for additional MRI's.

Prior to deregulation, there were 35 hospitals that maintained in-hospital MRI's. Since deregulation, virtually every Ohio hospital of any size now has an in-house MRI.

Radiation Therapy

Freestanding radiation therapy facilities and radiation therapy programs in hospitals were deregulated in March of 1998. Prior to deregulation, there were approximately 10 freestanding (non-hospital based) radiation therapy facilities in Ohio. The Department of Health in July 1999 listed 28 such facilities and an additional 6 notice of intent for freestanding radiation therapy facilities have been filed since July 1999. It is difficult to know how many hospitals maintained radiation therapy services prior to deregulation, but only two hospitals have added the service since deregulation.

Ambulatory surgery facilities

This is an area of the high activity and the most local contention. ASF's have been deregulated in MSA areas since May 1, 1996 and in rural areas since May 1, 1997. An ASF is defined as any place where outpatient surgery is performed that is not in the same building where inpatient services are rendered. In 1995 prior to deregulation, the Department of Health listed 31 ambulatory surgery facilities in Ohio. As of the end of August 2001, there are 186 such facilities actually operating in Ohio or under construction. Of these 186, approximately 30 are eye surgery only facilities.

The vast majority of the new ASF's are physician owned and operated, although there are some chain operations as well. A somewhat hidden result of the certificate of need deregulation is the effect that physician owned ASF's or the threat of a physician owned ASF has had on the smaller communities. In several one and two hospital towns, the physicians have approached the hospital with their plan to build an ASF and propose to "back-off" from the project only if the hospital will use its capital to build the facility and let the physicians have a large share of the profits or if the hospital will give the physicians more management control of the hospital. This has had the effect of pitting hospitals against

physicians in several Ohio communities with some rather unpleasant results. Obviously, the hospital does not want to build an ASF for physicians' profit; on the other hand the hospital cannot afford to lose much outpatient surgical business and hope to survive. Some hospitals and physicians have agreed to joint venture ASFs; other hospitals are toughing it out and have threatened to revoke staff privileges against any physician that invests in a competitor operation with the hospital. This remains the most difficult problem with the deregulation of CON.

Outpatient dialysis

Outpatient dialysis stations located inside a hospital were deregulated in May 1995. Freestanding outpatient dialysis centers in MSA areas were deregulated in May 1996 and in rural areas in May 1997. Prior to deregulation, the Ohio Department of Health listed 1,053 existing certified outpatient dialysis stations and had determined there was a need for an additional 40 stations in the state. Since May 1995, over 1,000 new dialysis stations have been added in Ohio for a 100 percent increase in stations. These new stations represent: 1) additions to existing dialysis programs in hospitals and freestanding facilities; 2) new hospital-based dialysis programs; and 3) new freestanding facilities. New dialysis stations continue to be added on a regular basis in 2001 and there has not been a slow-down in expansion. Since it is doubtful that there has been a 100% increase in the number of dialysis patients to match these new stations, it is assumed that these dialysis facilities are operating fewer shifts than were the facilities before deregulation. Prior to deregulation, most dialysis facilities operated three, and in some cases, four shifts. It is likely that most of these have decreased to two shifts.

Summary

The two main characteristics of this deregulated state are 1) a significant loss of inner city hospitals; and 2) a substantial increase in ambulatory surgery facilities and other freestanding facilities. We have no useable statistics on capital expenditures that have occurred during since deregulation.

Website information: **http://www.bricker.com/publications/articles/71.asp**

Library

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

March 28, 2006

Honorable Peggy Wilson
Alaska State House of Representatives
Chair, Health and Social Services Committee
State Capitol, Room 108
Juneau, AK 99801-1182

Re: HB 287 – Certificate of Need

Dear Representative Wilson:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

HB 287 would eliminate the Certificate of Need program in all boroughs with the exception of those with fewer than 25,000 people. ASMA supports HB 287 and urges you and all other members of the Health and Social Services Committee to support it as well.

For over twenty years ASMA has opposed certificate of need regulations on behalf of patients, access to care, quality of care, and the economic harm that results. The continuation of Alaska's Certificate of Need program is based on unproven assumptions of cost savings and quality outcomes.

The Department of Justice released a report in 2004, based on 27 days of DOJ/FTC Joint Hearings on Health Care and Competition Law and Policy, held from February through October 2003: an FTC sponsored workshop in September 2002; and independent research. The hearings gathered testimony and written comments from more than 300 participants, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from anti-trust and economics to health care quality and informed consent. Almost 6,000 pages of transcripts of the hearings and workshop and all written submissions are available on the DOJ's and FTC's website. The conclusion: reconsider whether certificate of need programs best serve their citizens'' health care needs. On balance, the DOJ and the FTC believe that such programs are not successful in containing health care costs, and they pose serious anticompetitive risks that usually outweigh their purported economic benefits. [1]

The American Medical Association policy certificate of need programs is also consistent. It's conclusion: our AMA believes that there is little evidence to suggest that certificate of need programs are effective in restraining health care costs or in limiting capital investment. In the absence of such evidence, the AMA reaffirms current policy opposing the extension of certificate of need to private physicians' offices. (CMS Rep. D, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00) [2]

[1] http://www.usdoj.gov/atr/public/press_releases/2004/204711.htm

[2] http://www.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/HnE/H-205.999HTM&s_t=certificate+of+need&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&&nth=1&&st_p=0&nth=1&

An article in the Anchorage Daily News on March 10, 2006, reported on a study done by University of Alaska researchers. It reported that last year's statewide health care spending was estimated to be $5.3 billion, which represents 1/6th of the value of all goods and services produced that year. This is better than three times the amount of health care expenditures in 1991 of $1.6 billion. We need to try a different approach.

In late August 2005, the Department of Health and Social services noticed proposed regulations that set the review standards for the Alaska Certificate of Need Program. ASMA provided written testimony opposing adoption of those proposed regulations. Those comments contained some of the same remarks provided in this testimony. You may wish to get the record of the testimony provided pertaining to those proposed regulations (including ASMA's). For example, as a urologist, I reviewed the Review Standards for lithotripsy and found the methodology has no basis in Alaska. Another was the Standard for computed tomography that favored the "sixteen slice" CT scanner that hospitals are installing to do cardiac imaging. Most individuals would be adequately served by single slice scanners at a fraction of the cost and at a fraction of the radiation dose.

My experience (as a health care consumer and patient) also evidences the problems with the Certificate of Need. My recent colonoscopy, done at a physicians owned entity, which would be precluded under the proposed regulations, was 40% of the cost had it been at one of the Anchorage area hospital endoscopy suites.

Those efforts to codify the Review Standards were well meaning but they are counterproductive. Consider that there is an entire universe of services and products that grow every day as new research and technologies come along. We are on the cusp of a revolution with the decoding of the human genome and the nanotechnology. There are currently 400 new drugs and treatments in clinical trials as well as millions undergoing basic research. At the same time, people are rediscovering a host of ancient practices such as herbal medicines, native treatments and acupuncture that were nearly lost in modern medicine's birth of penicillin.

No one can predict exactly how empowered consumers and advances in health care will behave. But that is the point. Free markets are effective because they are unpredictable and solve problems in ways that no one anticipates. (Note GOOGLE). And that is why a market-based system is essential.

ASMA urges you, as well as the other HESS Committee members, to support HB 287.

Sincerely,

By: Kevin Tomera, MD President
For: The Alaska State Medical Association

Bradners'
Alaska Legislative Digest
An Inside View
Policy, resources, business, construction, municipal, schools, and more!
PUBLISHERS: Mike Bradner, Tim Bradner Business Office: 522-0195 / 3057 South Circle Anchorage, AK 99507 Fax: (907) 522-1763

March 30, 2006
No. 13/06

On the oil tax bills . . . .

Differences and consensus becoming clearer

The major issues yet to be resolved in oil tax legislation as well as areas of consensus are becoming clearer. The Senate Resources Committee finished its work on SB-305 March 29 and held it for a final look-over before sending it on to the Finance Committee. Meanwhile the House Finance Committee held hearings last week on the House Resources version of the bill, HB-488.

- Continued on page 8

House budget likely a non-budget

The House passed a $7.5 billion federal/state funded budget, with a 6 percent increase in draw on state general funds over the current year. This is likely a shell of a budget as will be the Senate budget. This year may require an old fashioned budget free conference to build a real budget, one that may include capital funding and so-called "discretionary funding."

Senate may strip public broadcast funding

A Senate Finance Committee subcommittee chaired by Sen. Fred Dyson, R-Chugiak, has voted to recommend to the full Finance Committee that funding for public broadcast be stripped from the budget. The subcommittee was to close out as we go to press.

- Continued on page 6

Health facility certificate of need debate opens

The House Health, Education, and Social Services last week opened hearings on repeal, or serious modification of the state controlled "Certificate of Need" process that now controls the construction of certain kinds of medical facilities. This is a debate that will not end this session, and is driven, in part, by a now-certified citizens initiative aimed at the 2008 ballot. The initiative is a full repeal, so legislators can either pass a modification bill sufficient to allow the initiative to be removed from the ballot, or let voters decide the issue.

- Continued on page 6

Alaska Legislative Digest & Alaska Economic Report
web page: www.akreports.com ISSN 3322-0023

. . . Business . . .

Auto dealer fee disclosure proposed

In what appears to be a last-ditch effort to salvage their proposal to pay auto dealers for vehicle title and registration paperwork they now complete as a customer service, the sponsors of HB-344 have added a disclosure provision that at least one of them has adamantly opposed in a separate bill.

Sponsored by Reps. Vic Kohring and Jay Ramras, the bill would allow auto dealers who have been contracted as agents of the Division of Motor Vehicles to keep up to 7.5 percent of the state fees they collect. At a March 28 hearing before the House State Affairs Committee, Ramras proposed a revised draft including a requirement that dealer/agents disclose to car buyers the fees they charge for their services and state or municipal fees that are also imposed.

The revised bill was not adopted as the work document and Chair Rep. Paul Seaton (R-Homer) immediately put the measure aside without indicating plans for future hearing. A similar requirement for disclosure of dealers' so-called "doc fees" is a central element of HB-383, now awaiting a House floor vote.

ESC payments for worker training

Legislation that would divert a fraction of workers unemployment contributions to fund a six-year training program for pipeline and other construction jobs is expected to move out of the Senate Labor and Commerce Committee next week. SB-309 got unanimous support from employers, labor unions, individual workers and the state at a March 28 hearing. The bill was held for a March 30 hearing but pulled from that agenda by Chairman Con Bunde (R-Anch.).

The bill is intended to help fill the current construction worker shortage with state residents and prepare them for more than 8,600 jobs expected to be created when construction of a gas pipeline begins. It does not increase any taxes, but directs the diversion of .10 percent of employee contributions to a new holding account intended to be appropriated in grants to the Alaska Works Partnership, Inc. or successor nonprofits. The training will focus on construction jobs ranging from home building to highway and pipeline-related crafts. Grantees will be required to submit annual reports to the Department of Labor each Nov. 1.

Public broadcast funding - *continued*

- Continued from page 1

One interesting thing in the subcommittee action is that they did not reduce the total of funding, but reallocated funding to functions like public defenders and others. This suggests that the funds are still there to be replaced, although after using the item to do conference committee wrestling with the House.

Certificate of need - *continued*

Continued from page 1

We will be following the certificate-of-need (CON) debate in some detail, but it is also a complex issue needing print space. HB-287 is by Reps. Lynn, Coghill, Kohring, and Chenault, all Republicans. Reps. Lynn and Coghill are also sponsors of a voter initiative, eliminating all CON requirements. Certificate-of-need is a process requiring certain medical facilities over $1 million to obtain a CON from the Department of Health and Social Services. In recent years there have been increasing pressure from the physicians community to form (and own) outpatient specialty facilities, such as surgical and imaging centers. Hospitals see this draining their efficiency. The strategy of entrepreneurial physicians is to push the initiative, which could not come to the ballot prior to 2008, but offer opportunity for a modified version (HB-287), the latter which in present form already retains CON for psychiatric and nursing home facilities.

ASHNHA
Alaska State Hospital and Nursing Home Association
Rod L. Betit, President/CEO

ASHNHA Testimony on HB 287 - Communities Exempt from Certificate of Need (CON)

As we read the provisions of HB 287, the bill would remove the requirement for CON review of all health care projects in the communities of Anchorage, Fairbanks, Homer, Juneau, Palmer/Wasilla, and Soldotna. ASHNHA's membership does not support this legislation for the following reasons:

- **CON is an important public health policy tool.**
  Certificate of Need does not prohibit needed growth in Alaska's health care infrastructure, but rather is a process that assures additional services are needed in the area being proposed. Without a strong CON process, over-building of health care facilities would occur and new medical services may not be developed in the desired locations.
  36 states plus the District of Columbia continue to require CON approval for one or more categories of health services. In addition, some states have discontinued CON and replaced it with an outright moratorium against new construction in certain areas further underscoring the critical need to restrain unneeded growth.

- **Recently finalized State regulations should be given an opportunity to work.**
  In 2004 the Alaska Legislature made important changes to the CON law. State regulations implementing these changes have just recently been finalized after a lengthy review and public comment process. ASHNHA believes these carefully deliberated regulations should be given a chance to work.
  Since reopening the CON process in 2005, the Department of Health & Social Services has approved a number of new health care projects and has allowed others to proceed without CON review. Well documented applications for additional service capacity are receiving favorable treatment under the new regulations to ultimately better serve Alaskans throughout the State.

- **Over investing in health care facilities, equipment and technology will place the financial stability of community hospitals at risk.**
  When there are too many providers for a finite number of health care events, community hospitals are most at risk as revenues from their more profitable lines of business shrink. This leaves community hospitals struggling to finance the full array of services it must offer on a 24/7 basis to all residents regardless of ability to pay.

426 MAIN STREET • JUNEAU, ALASKA • 99801
PHONE: 907.586.1790 • FAX: 907.463.4573

- **Over building of medical infrastructure will further exacerbate the workforce shortage situation and drive up health care costs as providers compete to hire needed medical staff from this limited pool.** Alaska is already facing a critical shortage of physicians and nurses. This situation is not expected to improve in the short term. Many of the projects subject to CON review would require the most specialized professionals in radiology and surgery. If we do not control the growth in Alaska's medical infrastructure we will see staffing shortages in our hospitals and nursing homes beyond anything we have experienced to date.

ASHNHA believes the CON process is not overly burdensome to applicants who desire to enter the health care market or who desire to expand their services. Most CON applications are being approved. Those CON applications that have not been approved failed for one or more reasons. Either the project was not justified based on the criteria established by the Alaska Department of Health and Social Services to guide CON decisions, or the projects offered services in an area of the State that did not fit the need, or some other major problem existed with the application. Some of the denied projects can be resubmitted and approved once the problem areas are corrected. ASHNHA's members believe this is a rational and fair way to make medical care infrastructure decisions for all Alaskans.

ASHNHA's members respectfully urge you not to move this bill forward.

ASHNHA Represents the Following Alaska Health Care Facilities:

Alaska Regional Hospital, Alaska Native Medical Center, Alaska Pioneer Home System, Bartlett Regional Hospital, Bassett Army Community Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kanakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mary Conrad Center, Mat-Su Regional Hospital, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, USAF 3rd Medical Group- Elmendorf, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, Alaska Psychiatric Institute, North Star Behavioral Health System, Wildflower Court Nursing Home.

Status Report on Ohio After Deregulation from Certificate of Need

Authored by Gretchen McBeath, Bricker & Eckler LLP
Presented by Thomas R. Piper, MacQuest Consulting
Alaska House Health, Education, and Social Services Committee
at the March 28, 2006 hearing related to House Bill 287

In 1995 the Ohio General Assembly repealed Ohio's twenty year certificate of need program for all facilities, services, beds, capital, and equipment, except for long term care facilities which remain indefinitely subject to certificate of need review. This article examines the situation in Ohio after deregulation and the information is current through September 2001 (no info tracked thereafter).

Deregulation Schedule

Ohio phased out its certificate of need program during a period starting in May 1995 and concluding March 1, 1998. Currently, everything in Ohio is deregulated and no longer subject to CON except for long-term care services. All activities associated with the long-term care industry, both freestanding and hospital-based, continue under certificate of need indefinitely. The Ohio phase-out took place according to the following schedule:

Solid organ transplantation	March 1, 1998
Bone marrow programs	March 1, 1998
Cardiac catheterization	March 1, 1998
Open heart surgery	March 1, 1998
New hospitals	May 1, 1997
Freestanding dialysis centers	May 1, 1996 (MSA); May 1, 1997 (rural)
Hospital-based dialysis	May 1, 1995
Ambulatory surgery facilities	May 1, 1996 (MSA); May 1, 1997 (rural)
Freestanding/mobile MRI	May 1, 1996 (MSA); May 1, 1997 (rural)
Hospital-based MRI	May 1, 1995
Capital improvements	May 1, 1995
Low risk OB/newborn	May 1, 1995
High risk OB/newborn	March 1, 1998
Hospital beds	May 1, 1995
Linear accelerators	March 1, 1998
Gamma knives	March 1, 1998
Other equipment	May 1, 1995

Ohio does not have a hospital licensure program but individual services are subject to quality review, similar to a licensure program. These services include

cardiac catheterization, open heart surgery, obstetrics and newborn, radiation therapy, pediatric ICU units, solid organ transplantation services, bone marrow and stem cell transplant programs. In addition, psychiatric units and obstetric/newborn units are subject to licensure. Most freestanding facilities such as ASFs, diagnostic imaging, dialysis are licensed. These licensure and quality review programs have not been a barrier to entrants seeking to establish new facilities and services.

Hospitals

New hospitals in Ohio have been deregulated since May, 1997. Although there have been some new hospitals built in Ohio, and a few more on the drawing board, the bigger story is the number of hospitals that have closed since deregulation.

	Before Deregulation		December 2000	
	# Hospitals	Beds	# Hospitals	Beds
Urban hospitals	62	25.091	56	20,994
Community hospitals	76	16,019	71	15,420
Rural hospitals	52	4,240	46	3,929
Psych/alcohol/rehab hospitals	24	1,239	18	1,035
Hospitals within a hospital	0	0	15	528
Total	214	46,589	206	41,906

The closure situation has been most dramatic in the inner cities where 9 long-standing large hospitals have closed. The breakdown of the closures and openings is as follows:

Hospitals Closed Since Deregulation

Type of Hospital	Number	Number of Beds
Urban/general	11	3,602
Mid-size community	6	1,001
Rural	4	265
Psychiatric/alcohol	6	538
Total	27	5,406

Hospitals Opened Since Deregulation

Type of Hospital	Number	Number of Beds
Urban/cardiac	2	71
Mid-size community	1	206
Rural	1	24
Hospitals within a hospital	15	528
Total	19	829

There are at least two additional hospitals either planned or actually under construction. One is a full-service hospital in Toledo and the other is a cardiac

hospital in Columbus. The Toledo hospital will have 70 beds and plans to open in November 2001.

It is significant that at least two of the large inner city hospitals that have closed were closed at a result of movement to the suburbs. In these cases, the inner city hospital acquired a small suburban hospital, expanded it, transferred the tertiary services from the inner city facility and then closed the inner city facility. This is obviously an attempt to capture more of the affluent suburban market that is currently not coming to the old inner city hospitals.

Hospital Beds

Ohio has experienced a decline in the number of hospital beds since the 1995 deregulation from certificate of need. As shown below, total hospital beds at the end of 2000 had decreased by 5,456. Most of this decrease is a direct result of the closures of the large urban hospitals discussed above.

Type of bed	Before deregulation	December 2000
Special care	3,284	3,097
Med/surg	31,331	27,256
Obstetrics	2,715	2,462
Pediatric	2,808	2,649
Psychiatric	3,610	3,266
Rehab	1,618	1,790
Alcohol	1,530	928
Burn	111	103
Total	47,007	41,551

***NOTE: The total bed numbers shown at the end of December 2000 here and the closures and openings of beds (above) do not precisely match due to the different time periods from which the two sets of numbers were derived. Also, bed numbers in both listings exclude nursery beds and SNF beds.**

Cardiac Services

Cardiac catheterization and open heart surgery were deregulated effective March 1, 1998. Ohio law currently prohibits cath labs and open heart surgery unless performed in a hospital. As of September 2001, the following statistics apply to cardiac services.

	Before deregulation	After deregulation
Number of Ohio hospitals*	190	173
Hospitals with cardiac cath	86 (42%)	94 (54%)
Hospitals with open heart surgery	38 (20%)	50 (29%)

***Includes only hospitals with medical/surgical capabilities and excludes psychiatric and other specialty hospitals**

Imaging

MRI's located in an existing hospital were deregulated as of May, 1995. Freestanding diagnostic imaging centers (a center which includes either an MRI or a CT scanner or both) were deregulated in MSA areas as of May 1, 1996 and in rural areas as of May 1, 1997. Immediately before deregulation, the Department of Health recognized 23 non-hospital-based mobile or freestanding MRI's in Ohio. As of July 1999, the Department listed 126 non-hospital-based mobile or freestanding MRI's. Since July 1999, another 65 notices of intent have been filed for additional MRI's.

Prior to deregulation, there were 35 hospitals that maintained in-hospital MRI's. Since deregulation, virtually every Ohio hospital of any size now has an in-house MRI.

Radiation Therapy

Freestanding radiation therapy facilities and radiation therapy programs in hospitals were deregulated in March of 1998. Prior to deregulation, there were approximately 10 freestanding (non-hospital based) radiation therapy facilities in Ohio. The Department of Health in July 1999 listed 28 such facilities and an additional 6 notice of intent for freestanding radiation therapy facilities have been filed since July 1999. It is difficult to know how many hospitals maintained radiation therapy services prior to deregulation, but only two hospitals have added the service since deregulation.

Ambulatory surgery facilities

This is an area of the high activity and the most local contention. ASF's have been deregulated in MSA areas since May 1, 1996 and in rural areas since May 1, 1997. An ASF is defined as any place where outpatient surgery is performed that is not in the same building where inpatient services are rendered. In 1995 prior to deregulation, the Department of Health listed 31 ambulatory surgery facilities in Ohio. As of the end of August 2001, there are 186 such facilities actually operating in Ohio or under construction. Of these 186, approximately 30 are eye surgery only facilities.

The vast majority of the new ASF's are physician owned and operated, although there are some chain operations as well. A somewhat hidden result of the certificate of need deregulation is the effect that physician owned ASF's or the threat of a physician owned ASF has had on the smaller communities. In several one and two hospital towns, the physicians have approached the hospital with their plan to build an ASF and propose to "back-off" from the project only if the hospital will use its capital to build the facility and let the physicians have a large share of the profits or if the hospital will give the physicians more management control of the hospital. This has had the effect of pitting hospitals against

physicians in several Ohio communities with some rather unpleasant results. Obviously, the hospital does not want to build an ASF for physicians' profit; on the other hand the hospital cannot afford to lose much outpatient surgical business and hope to survive. Some hospitals and physicians have agreed to joint venture ASFs; other hospitals are toughing it out and have threatened to revoke staff privileges against any physician that invests in a competitor operation with the hospital. This remains the most difficult problem with the deregulation of CON.

Outpatient dialysis

Outpatient dialysis stations located inside a hospital were deregulated in May 1995. Freestanding outpatient dialysis centers in MSA areas were deregulated in May 1996 and in rural areas in May 1997. Prior to deregulation, the Ohio Department of Health listed 1,053 existing certified outpatient dialysis stations and had determined there was a need for an additional 40 stations in the state. Since May 1995, over 1,000 new dialysis stations have been added in Ohio for a 100 percent increase in stations. These new stations represent: 1) additions to existing dialysis programs in hospitals and freestanding facilities; 2) new hospital-based dialysis programs; and 3) new freestanding facilities. New dialysis stations continue to be added on a regular basis in 2001 and there has not been a slow-down in expansion. Since it is doubtful that there has been a 100% increase in the number of dialysis patients to match these new stations, it is assumed that these dialysis facilities are operating fewer shifts than were the facilities before deregulation. Prior to deregulation, most dialysis facilities operated three, and in some cases, four shifts. It is likely that most of these have decreased to two shifts.

Summary

The two main characteristics of this deregulated state are 1) a significant loss of inner city hospitals; and 2) a substantial increase in ambulatory surgery facilities and other freestanding facilities. We have no useable statistics on capital expenditures that have occurred during since deregulation.

Website information: **http://www.bricker.com/publications/articles/71.asp**

Linda Miller

From: Rep. Peggy Wilson
Sent: Monday, March 27, 2006 1:13 PM
To: linda_miller@legis.state.ak.us
Subject: FW: *****SPAM***** Fiscal Note Analysis- HB 287
Attachments: Thoughts on fiscal note for Alaska.pdf

From: Jermey Hayes [mailto:jhayes@admin.apcak.net]
Sent: Monday, March 27, 2006 12:51 PM
To: Rep. Peggy Wilson; Rep. Tom Anderson; Rep. Lesil McGuire; Rep. Berta Gardner; Rep. Sharon Cissna
Subject: *****SPAM***** Fiscal Note Analysis- HB 287

Representatives—

The fiscal note attached to HB 287 was analyzed by one of the countries leading experts on CON policy out of Washington State by the name of John Barnes. He is a policy analyst and the author of a January 2006 study and Policy Brief which is being cited as the most credible and recent data available on Certificate of Need policy. I've attached his response to the fiscal note on HB 287 to this e-mail correspondence. There is a hearing on HB 287 scheduled for tomorrow at 3:00 PM and I feel this is important material to digest beforehand. Thank you kindly for your time, and have a wonderful day!

Jeremy Hayes
Assistant Administrator
Advanced Medical Centers of Alaska

Pain Management - Sports Medicine & Rehab - Health Psychology

WASHINGTON
POLICY CENTER

John Barnes, Policy Analyst
jbarnes@washingtonpolicy.org

Concerns regarding the fiscal note for Alaska's HB 287 (2006)

Scaling Down Certificate of Need Requirements

- Too little explanation of the fiscal note estimates. How *exactly* did they arrive at these numbers? This is especially important if the crux of the argument against scaling down CON laws is the fiscal impact on the state.

- The department predicts $2.7 million in expenditures for Cardiac Hospitals starting in FY2010, but admits there have not been any specific inquiries for such facilities.

- The department admits uncertainty with the numbers for various reasons, but insists their estimates are "conservative." This does not make sense. If this is true uncertainty, then their estimates could be high as well.

- In general, the department makes estimates and projections for several years down the road. You cannot assume this to be accurate. Financial estimates for that far out are laden with problems because of shifting variables and unpredictable circumstances. The general unreliability of state projections and projection methodologies is a large reason why CON laws do not help control health care costs. You cannot centrally-plan for the present or the near future, much less 6 or 7 years down the road.

- The department makes a $2.7 million projection for Orthopedic Hospitals without providing demonstration of interest. They state simply that "it is only a matter of time before they move to Alaska," and make a projection for FY2012. Fiscal notes ought not be based on the *supposed* inevitability of anything, and a projection for 6 or 7 years down the road is informed speculation at best due to shifting economic and demographic factors.

- In general, the calculation methodology (that which can be seen, at any rate) is suspect. The department is basing its estimation of facilities that would be built in a post-CON era on letters of intent and applications received in the past. But letters and applications are filed with the understanding that CON may not be granted. They are filed in an attempt to enter a market where providers are insulated from competition, where success is much more assured. When there is no CON barrier, providers have to be more careful in deciding to enter the market, and some who filed letters and applications would not actually proceed with projects because the likelihood for success changed. **You cannot assume that the number of letters and applications reflect the likely number of new facilities.**

- The fiscal note is based on the *assumption* that a massive supply surge will follow a CON downscaling. That is not necessarily true. A 1998 empirical study published in *Journal of Health Politics, Policy, and Law* examined health spending between the late 1970s and 1993

and found that in states that repealed CON laws, there was no surge in health spending.[1] This evidence contradicts the fiscal note's projections. [If this surge does occur, it will reflect the fact that the supply was abnormally depressed due to CON in the first place. In the long run Alaska will experience a leveling off of supply that reflects true demand.]

- A 2003 study by three leading authorities in the field of health policy found that aggregate state-level data from 1981 through 1998 shows states that repealed their CON and moratorium laws had no significant growth in either nursing home or long-term care Medicaid expenditures.[2] This evidence contradicts the fiscal note's projections, and *even if these facilities are not included in the bill, this evidence calls into question the department's methodology for fiscal impact and its assumptions in general.*

- Fiscal note numbers do not reflect the potential for cost reduction in the aftermath of CON downscaling. CON laws curtail services and facilities, often forcing patients into more expensive substitutes, thus increasing costs for patients or third-party payers. EXAMPLE: if nursing home beds are not available, the discharge of patients from more expensive hospital beds may be delayed or patients may be forced to use a more expensive nursing home.

- Fiscal note numbers do not take into account the potential for savings through reduced administrative costs, less personnel time, etc. If less time and resources are being spent running CON, that's money saved. This is true for business as well. Many businesses have entire departments devoted to just the CON process.

[1] Christopher Conover and Frank Sloan. "Does removing certificate-of-need regulations lead to a surge in health care spending?" *Journal of Health Politics, Policy, and Law*, Vol. 23, Issue 3.

[2] David C. Grabowski, Robert L. Ohsfeldt, and Michael A. Morrisey. "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures," *Inquiry* 40 (Summer 2003): 146-157.

Linda Miller

From: Kala Ladenheim [kala.ladenheim@ncsl.org]
Sent: Wednesday, March 22, 2006 1:19 PM
To: Linda Miller
Cc: paul deyoung
Subject: Fw: Certificate of Need information

Hi Linda,
I apologize, this got pushed back from Paul's plate by a competing deadline. Here is some preliminary material. The short version is that depending on the study you look at (see below) prices may go up, down or stay the same--mostly, there doesn't seem to be much effect one way or another. There seems to be a long-standing consensus that CoN isn't very effective, which would mean they don't do any good but also don't do harm. Hospital CoN has been critiqued as a way for dominant providers to maintain control over a market and raise barriers to entry. These days there seem to be so many other anticompetitive forces--consolidation of markets, concentration of providers into chains, privatization and conversion of not-for-profits--that would have a greater impact.

CoN for hospitals fell out of favor in the 1990s when market competition via managed care was seen as a way to exert fiscal discipline. However, CoN and related practices continue to be a part of the discussion around reconfiguring long term care delivery systems (which is why I cite a couple of items on this issue below), expensive diagnostic technologies, and other delivery system changes.

I've also heard discussions that CoN is redundant because capital markets will exercise necessary constraint on excess growth in their practice of due diligence. However, the literature on induced demand does seem to be strong--that if services are available, people are likely to be encouraged to use them even beyond the point of medical necessity. This suggests that if there is a public hospital bonding authority you may want to have some sort of CoN-like review not as a regulator but as a prudent investor.

The most detailed recent study I found suggested that costs and benefits as a result of the CoN regulation were a wash, but that the cost of the regulatory process itself was high (both to regulators and the industry), tipping scales against CoN. That is not the same as saying that markets became more efficient when it was removed--am not aware of any studies that suggest that.

Paul may be able to follow up with more detail and more specific studies.

Here are a couple of other considerations:

One thing to consider is that CON is actually very different from state to state in terms of which providers are affected for what items; the impact will also be affected by the kind of market the state has. Some states mostly regulate nursing home supply, for example, while others focus on big ticket technologies like high end imaging. Studies may be inconclusive because CoN helps some markets function and hurts others.

A criticism of the earliest study was that it ignored something called "endogeneity." The terms means that the cause and effect are intermingled, and the thing that you think is the result of the policy change (prices going up) is also the thing that led you enact the policy. So, you have to be careful to make sure your are not measuring a cause or a general background trend when you think you are measuring an effect.

An example of endogeneity would be: states are likelier to pass a CoN law if they have a lot of providers who compete to "induce demand", for example, a technological arms race. Thus, if too many hospitals buy MRIs, costs in the community are higher because they do more MRIs than are strictly medically indicated to pay for equipment,. These are expensive markets, with providers competing to induce demand and steeper trendlines than other markets. A comparison with other states may suggest that CoN raises prices, especially if their trends are compared with rural state s with mostly sole community providers where prices are more influenced by the overall economy and community benefit demands. But what may be getting measured is underlying differences that are part of the reason for the law being introduced, not differences that result from the law. 00Hard to sort it out!!

Here are some of the arguments being made on both sides of the question. The tone is pretty heated on both sides, which to me is always a sign that there is more ideology than information out there.

----- Original Message -----
From: Kala Ladenheim
To: Kala Ladenheim ; paul deyoung
Cc: Tara Lubin ; paul deyoung
Sent: Monday, March 20, 2006 5:41 PM
Subject: Re: Certificate of Need information

Some items that may be useful.

Apparantly this round is triggered by a 2004 FTC/DoJ paper, http://www.ftc.gov/opa/2004/07/healthcarerpt.htm critiqued here by the CoN trade association as being based on a mix of wishful thinking by industry, dismissal of recent research and reliance on 20-year-old flawed studies.. http://www.ahpanet.org/images/AHPAcritiqueFTC.pdf

This looks like a good literature review. Overall: neutral impact both going an and taking out, main fiscal impact is due to not having regulation--the regulatory costs themselves. Both financial and quality impacts were seen going in both directions.
http://www.hpolicy.duke.edu/cyberexchange/Regulate/CHSR/HTMLs/F9-Cert%20of%20Need.htm

- *Government Regulatory Costs.* Total staffing for CON agencies by state are reported in DHHS (1986).
- *Indirect Costs: Impact on Health Expenditures.* Using HCFA time series cross section state level per capita spending data for 1969, 1972 and 1976-1982, Lanning, Morrisey and Ohsfeldt found that CON was associated both with an increase in per capita hospital spending (20.6 percent) and per capita spending on other health services (9.0 percent), for a net increase of 13.6 percent in health spending overall. **Using the same HCFA data from 1980-1993, Conover and Sloan (1998) found that CON had a long run effect of reducing hospital spending per capita by 5 percent, but there was no significant impact on overall health spending per capita. In a recent unpublished update that makes use of these data for the 1980-1998 model, Sloan and Conover find that dropping CON for acute care services had no significant effect on total per capita health spending, components (hospital and physician spending) or Medicare spending per eligible. Stringent CON was associated with a statistically significant reduction in hospital spending, but not in overall per capita expenditures, along with a –1.8 percent decline in Medicare spending per eligible.**

CoN isn't one-dimensional so cost impacts probably aren't either. Here's a good run-down of different types of regulation in CoN , prepared for the Illinois health planning board. http://www.idph.state.il.us/about/hfpb/GSU%20CON%20Assessment%20Summary.pdf

GA CON study commission--might be worthwhile to find some of theitems cited
http://www.gcn.org/Services/PublicPolicy/PolicyUpdates2005State/CertificateofNeedStudyCommissionUpdate.aspx
http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.363/DC1

The Effects of CON **Repeal** on Medicaid Nursing Home and Long-Term ...
It is widely known that **certificate of need** (CON) programs have been ... 1987; The **Impact** of State Medicaid Nursing Home Policies on Utilization and ...
www.inquiryjournalonline.org/inqronline/?request=get-document& issn=0046-9580&volume=040&issue... - Similar pages

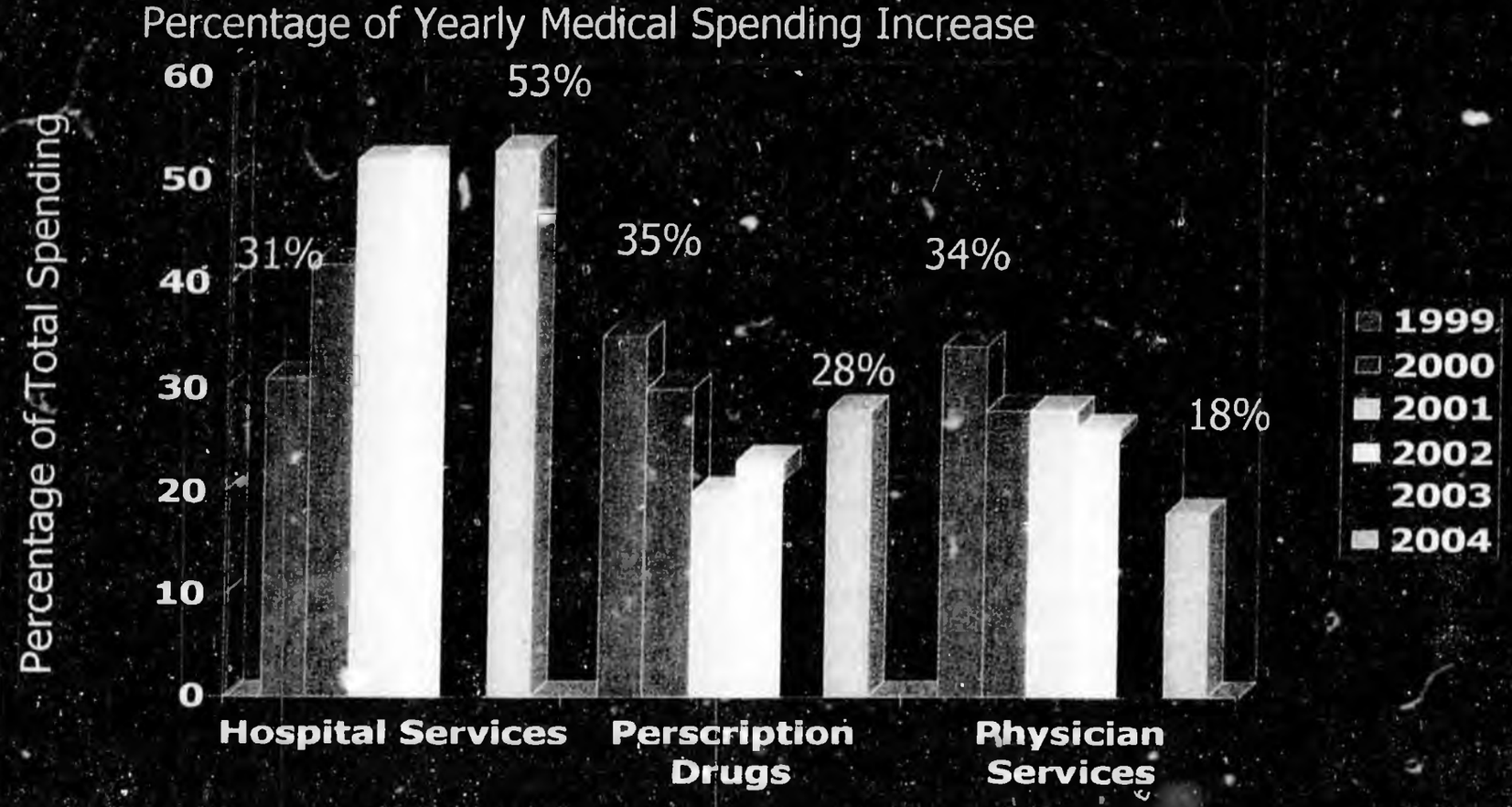
----- Original Message -----
From: Kala Ladenheim
To: paul deyoung
Cc: Tara Lubin
Sent: Friday, March 17, 2006 5:18 PM
Subject: Fw: Certificate of Need information

Can you do this info request? Touch base with Tara and me.
----- Original Message -----
From: Linda Miller
To: kala.ladenheim@ncsl.org

Sent: Friday, March 17, 2006 12:44 PM
Subject: Certificate of Need information

Hello Kala,
I am the HESS Committee Aide for Rep. Peggy Wilson and she has requested information on the the Certificate of Need. She specifically would like to know if in states where they have repealed the CON if the costs have went down. Any information you can provide to us would be very helpful. She will be hearing a CON bill in her HESS Committee on Tuesday, March 28th. Thanks for your help.
Linda Miller, MSW
HESS Committee Aide
Office of Representative Peggy Wilson
Alaska State Legislature

Spending Growth Continues To Be Dominated by Hospital Services



Employee Benefit Research Institute, Strunk, Gabel and Ginsburg, December 2004, Center for Studying Health System Change www.hschange.org

Form 990

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

OMB No 1545-0047

2003

Open to Public Inspection

Department of the Treasury Internal Revenue Service ▶ The organization may have to use a copy of this return to satisfy state reporting requirements

For the 2003 calendar year, or tax year beginning . and ending

Check if applicable: Address change; Name change; Initial return; Final return; Amended return; Application pending

Please use IRS label or print or type. See Specific Instructions.

C Name of organization: GREATER FAIRBANKS COMMUNITY HOSPITAL FOUNDATION, IN

D Employer identification number: 92-0035784

Number and street (or P O box if mail is not delivered to street address): P O. BOX 71396 Room/suite:

E Telephone number: 907-452-2955

City or town: FAIRBANKS State or country: AK ZIP + 4: 99707

F Accounting method: ☐ Cash ☒ Accrual ☐ Other (specify) ▶

Section 501(c)(3) organizations and 4947(a)(1) nonexempt charitable trusts must attach a completed Schedule A (Form 990 or 990-EZ).

H and I are not applicable to section 527 organizations

H(a) Is this a group return for affiliates? ☐ Yes ☒ No

H(b) If "Yes," enter number of affiliates ▶

H(c) Are all affiliates included? ☐ Yes ☐ No (If "No," attach a list See instructions)

H(d) Is this a separate return filed by an organization covered by a group ruling? ☐ Yes ☒ No

I Group Exemption Number ▶

J Website: ▶ N/A

K Type of organization (check only one) ▶ ☒ 501(c)(3) ◀ (insert no) ☐ 4947(a)(1) or ☐ 527

L Check here ▶ ☐ if the organization's gross receipts are normally not more than $25,000 The organization need not file a return with the IRS, but if the organization received a Form 990 Package in the mail, it should file a return without financial data Some states require a complete return.

M Check ▶ ☐ if the organization is not required to attach Sch B (Form 990, 990-EZ, or 990-PF)

L Gross receipts Add lines 6b, 8b, 10b to line 12 ▶ 21,292,746

Part I Revenue, Expenses, and Changes in Net Assets or Fund Balances (See page 18 of the instructions)

Revenue	1	Contributions, gifts, grants, and similar amounts received:			
	a	Direct public support	1a	282,358	
	b	Indirect public support	1b		
	c	Government contributions (grants)	1c		
	d	Total (add lines 1a through 1c) (cash $ 219,528 noncash $ 62,830)			1d 282,358
	2	Program service revenue including government fees and contracts (from Part VII, line 93)			2 16,409,542
	3	Membership dues and assessments			3 0
	4	Interest on savings and temporary cash investments			4 89,847
	5	Dividends and interest from securities			5 4,386,837
	6a	Gross rents	6a		
	b	Less: rental expenses	6b		
	c	Net rental income or (loss) (subtract line 6b from line 6a)			6c 0
	7	Other investment income (describe ▶ INTEREST INCOME)			7 132,668
	8a	Gross amount from sales of assets other than inventory	(A) Securities 0	8a (B) Other 11,125	
	b	Less: cost or other basis and sales expenses	0	8b 475,408	
	c	Gain or (loss) (attach schedule)	0	8c -464,283	
	d	Net gain or (loss) (combine line 8c, columns (A) and (B))			8d -464,283
	9	Special events and activities (attach schedule) If any amount is from gaming, check here ▶ ☐			
	a	Gross revenue (not including $ 282,358 of contributions reported on line 1a)	9a	0	
	b	Less: direct expenses other than fundraising expenses	9b	0	
	c	Net income or (loss) from special events (subtract line 9b from line 9a)			9c 0
	10a	Gross sales of inventory, less returns and allowances	10a		
	b	Less: cost of goods sold	10b		
	c	Gross profit or (loss) from sales of inventory (attach schedule) (subtract line 10b from line 10a)			10c 0
	11	Other revenue (from Part VII, line 103)			11 569
	12	Total revenue (add lines 1d, 2, 3, 4, 5, 6c, 7, 8d, 9c, 10c, and 11)			12 20,817,338
Expenses	13	Program services (from line 44, column (B))			13 8,497,445
	14	Management and general (from line 44, column (C))			14 483,699
	15	Fundraising (from line 44, column (D))			15 3,988
	16	Payments to affiliates (attach schedule)			16 0
	17	Total expenses (add lines 16 and 44, column (A))			17 8,985,132
Net Assets	18	Excess or (deficit) for the year (subtract line 17 from line 12)			18 11,832,206
	19	Net assets or fund balances at beginning of year (from line 73, column (A))			19 201,355,981
	20	Other changes in net assets or fund balances (attach explanation)			20 1,348,996
	21	Net assets or fund balances at end of year (combine lines 18, 19, and 20)			21 214,537,183

Profile

NOTES

The hospital's most recent cost reporting period is for their period ending 12/31/2004.
Inpatient claims data are for federal fiscal year ending 09/30/2004.
OP claims data are for calendar year ending 12/31/2004.
Data from other sources are described within headings.
Errata: Please notify us by email of any corrections or updates.

Identification and Characteristics

Last updated 11/09/2005 / Definitions

Name and Address: **Providence Alaska Medical Center**
3200 Providence Drive
Anchorage, AK 99508

Telephone Number: (907) 562-2211

Hospital Website: www.providence.org/alaska/pamc/defa...

Medicare Provider ID: 020001

Type of Facility: Short Term Acute Care

Type of Control: Voluntary Nonprofit, Church

Total Staffed Beds: 354

Total Patient Revenue: $715,350,595

Total Discharges: 15,569

Total Patient Days: 89,412

Clinical Services

Definitions

Cardiovascular Services
- Cardiac Rehab
- Cardiac Cath Lab
- Coronary Interventions
- Cardiac Surgery
- Vascular Surgery
- Vascular Intervention

Emergency Services
- Emergency Department

Neurosciences
- Electroencephalography (EEG)
- Sleep Studies

Oncology Services
- ACS/CoC Approved Cancer Program

Rehabilitation Therapies
- Physical Therapy

Wound Care
- Wound Care

Other Services
- Hemodialysis
- Home Health
- Inpatient Surgery
- Obstetrics

Subprovider Units
- Rehabilitation

Special Care
- Intensive Care Unit (ICU)

	Genitourinary Procedures	99	$1,147	$910
5	Cannula/Access Device Procedures	94	$1,837	$1,431

Beds and Patient Days by Unit

Definitions

	Available Beds	Inpatient Days
HOSPITAL (including swing beds)		
Routine Services	279	67,075
Special Care	75	17,690
Nursery	0	4,647
Total Hospital	354	89,412

Financial Statistics

Definitions

	$	%
Gross Patient Revenue	$715,350,595	96.00
Non-Patient Revenue	$29,779,693	4.00
Total Revenue	$745,130,288	
Net Income (or Loss)	$23,615,174	3.17