12128 HOUSE HESS

File
Supports CON
Repeal

Kurt West
Office of the Commissioner
P. O. Box 110601
Juneau, AK 99811-0601

Re: Medical Certificate of Need in Fairbanks

Dear Commissioner West:

I am in favor of competition in the health care industry.

Since I turned 60 years old I just fell apart. I have had two knee replacements (one in Anchorage and one in Seattle), a detached retina repaired (in Anchorage), and two spine surgeries (one in California and one in Florida). This all occurred in the last six years. It would have been so much better to have had some of these surgeries closer to home.

Years ago (before I fell apart), I had cataract surgery at Pacific Cataract and Laser Institute (PCLI). I was really impressed that the doctor had his own surgery room with his own instruments, placed in the same place before each surgery, and the same assistants.. It seemed so organized and clean. I work at a desk and I am much more efficient working at my own desk rather than at some other desk.

Outpatient surgery centers are the future in medical care. The experience of having a procedure in an outpatient center is very different than having the same procedure in the hospital. It feels more efficient, more personal, up-to-date, and cleaner. Maybe that isn't fact, but it definitely feels that way.

I would love for you to ask the administration at Fairbanks Memorial Hospital why they are not receptive to new doctors coming to Fairbanks and using the hospital. Right now we do not have a urologist and have to go to Anchorage to see one. I have been told that Dr. Tomera, a urologist, would like to have privileges at Fairbanks Memorial. Also, years ago, Dr. Stinson wanted to open a practice here (a pain clinic) and could not get privileges at FMH. At that time the hospital had a very out-of-date pain clinic. I know, I had an epidural there that was awful. If the administration at the hospital really cared about the community, wouldn't they want us to have access to doctors that we choose? Are they are protecting the patients or themselves? Please ask them.

Sincerely,

Suzanne Maestas
366 Slater Street
Fairbanks, AK 99701

(907) 456-6931 (907) 474-4885

Support repeal

Kim, Anna C (GOV)

From: Kim, Anna C (GOV)
Sent: Tuesday, July 03, 2007 1:07 PM
To: daniel.cogan.ctr@clear.af.mil
Cc: Kim, Anna C (GOV)
Subject: CON
Attachments: Kim, Anna C (GOV).vcf

Dear Mr. Cogan,

Thank you for taking time to write Governor Palin with your concerns regarding the Certificate of Need program. She has asked that I respond to you.

The Governor campaigned on a philosophy of support for more competition in health care services, and yes as easy as it seems to just toss CON out as you say, the Certificate of Need issue is very complex, and generally, a change to one part of the health care system will have an impact on other parts. Moving forward with consideration is imperative.

The State of Alaska takes an interest in the expenditure of public and private capital for health care facilities and services to further three public policy objectives:

1) maintain access to health care
2) assure high quality health care, and
3) contain health care costs.

The certificate of need, for several years, has been one tool of several the state uses to achieve these goals. The CON program is intended to promote responsible health facility and service development and to contain health care costs. Proposed projects are evaluated, using regulatory standards, to determine whether or not sufficient need exists in a community to support the addition of new health care facilities or services.

The Health Care Strategies Planning Council will consider this issue, among many other health care issues related to access, cost and quality of care, and a report by the Council is due to the Governor on Jan. 1, 2008. More information about the council can be found at: http://www.hss.state.ak.us/hspc/

Thanks you for your input and interest.

Anna

Anna Kim
Special Staff Assistant

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Tuesday, July 03, 2007 10:29 AM
To: daniel.cogan.ctr@clear.af.mil
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMa '@gov.state.ak.us]
Sent: Monday, July 02, 2007 4:01 PM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Web mail from: Daniel Cogan
address: 6049 Cogan Drive Fairbanks AK 99712
(907)978-2652

MESSAGE:
Dear Governor Palin,

I was wondering if there is any push to toss the Certificate of Need out of the State. If there in no move, I think there should be. There is no reason for Clinics to have a ·trangle- hold on the ammount of medicine available to the public.

·ncerely,
Daniel Cogan

daniel.cogan.ctr@clear.af.mil
PLEASE ADD TO E-NEWS

Doesn't Support Repeal

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Tuesday, January 22, 2008 10:47 AM
To: ttn@acsalaska.net
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Saturday, January 19, 2008 8:02 PM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Web mail from: Ms. Terri Nettles
address: 46290 Roosevelt Circle Soldotna AK 99669
907-262-9115

MESSAGE:
I am deeply disappointed that you have chosen to end the CON. I voted for you and encouraged others to do the same. I felt that you would make our state and communities better. I am sorry to say that what I have seen up to this point is very concerning and I do not believe I could support you if the election were to be held today. I want a governor who listens to the people. Karlene Jackson appointed a committee to look at the CON issue and they proposed keeping it at this time and to look at modifying it to protect healthcare in the smaller communities in the state. You have completely ignored the recommendation of this committee. I work in a hospital and I am afraid that at the rate we are going our state healthcare will be a complete mess by the time your term in office is up and thousands of Alaskans will suffer. I feel some responsibility for this as I helped to elect you. I don't feel very positive about supporting you. I wish I could say I am proud of what you are doing, but unfortunately I don't feel you are representing the people of Alaska, but your own agenda and that does not make for a good leader. I apologize if you feel I have been unfair to you in my assessment of your leadership and the CON issue. I would love to hear your side of why you would turn a deaf ear to those who supported you and voted for you to become Alaska's first woman governor. The healthcare in my own community will be negatively affected if you are allowed to remove the CON program. I have been an Alaskan for over 40 years and I chose to raise my family here. I love Alaska and I have never really been one to voice my opinion on an issue; however, this issue is too important. In my experience the issues that I have struggled with in the past have been shared by many of my friends, family members, and co-workers. I do hope you will take some time to reconsider your position and look for ways to support healthcare in Alaska instead of the healthcare vultures who just want to move into a community to scrape the bo!
nes clean of the local hospital and physicians that have been committed to providing quality healthcare to the people living in the smaller communities.

ttn@acsalaska.net

Kim, Anna C (GOV)

From: Kim, Anna C (GOV)
Sent: Tuesday, January 22, 2008 5:34 PM
To: 'ttn@acsalaska.net'
Subject: CON

Dear Ms. Nettles,

Thank you for writing Governor Palin concerning the Governor's Alaska Health Care Transparency Act. She has asked that I respond on her behalf.

The CON committee was appointed to bring forth recommendations to the Governor for consideration. The Governor could either adopt the recommendations or choose to go her own direction. The legislation is the direction that Governor would like to go and has support among members in the legislative body as well as providers in the communities.

If you would like to remain involved in this process, please see BASIS for scheduling and hearing days/times at:
http://www.legis.state.ak.us/basis/get_bill.asp?bill=SB%20245&session=25
http://www.legis.state.ak.us/basis/get_bill.asp?session=25&bill=HB337

The bills have both been referred to House HESS and Senate HESS committees and then next to House and Senate Finance committees. The bill is scheduled to be heard in House HESS Jan 24th at 3:00 pm and Senate HESS Jan 25th at 1:30 pm.

Thank you for sharing your views on this legislation.

Anna

Anna Clark Kim
Special Staff Assistant
Office of the Governor

Supports repeal

Anna Kim

From: Anna Kim [anna_kim@gov.state.ak.us]
Sent: Tuesday, April 03, 2007 3:29 PM
To: montanakidhammer@yahoo.com
Cc: anna_kim@gov.state.ak.us
Subject: CON

Dear Mr. Wetherington,

Thank you for writing Governor Palin regarding the Certificate of Need issue.

Contacting your legislators is a great start. In addition, as the Health Care Planning Strategies Council rolls out soon, they will also be involved in making recommendations regarding CON. There are many opinions out there, however, the Governor still believes in competition and access to affordable health care for Alaskans.

Thanks you for your support.

Anna

Anna Kim, Special Staff Assistant
Office of the Governor

Anna Kim

From: Governor Sarah Palin [governor@gov.state.ak.us]
Sent: Tuesday, April 03, 2007 2:23 PM
To: montanakidhammer@yahoo.com
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Monday, April 02, 2007 6:39 PM
To: governor@gov.state.ak.us
Subject: Health_Care

Web mail from: Mr. Neil \'Kid\' Wetherington
address: P.O. Box 73291 Fairbanks AK 99707

MESSAGE:
Dear Governor Palin,

As per the Certificate of Need issue, I have contacted my Legislative members (Thomas and Kelly).
Senator Thomas hasn't contacted me. Mr. Kelly has a conflict of interest, gave me "his" opinion, telling me i need to have it his way. My memory service me Mike works of me, I DO NOT work for him. I've voiced my opinion, again, to him and received no reply. I am able to re-elect him in District 7 in the future.

How can we help you, help the legislature support you, to help us (the cycle of reciprocity)? You and your cabinet are doing us proud, you are a true fiscal conservative, thank you.

Sincerely Submitted,

Neil Wetherington, The Montana Kid Hammer

montanakidhammer@yahoo.com

Wants

and CON

Anna Kim

From: Anna Kim [anna_kim@gov.state.ak.us]
Sent: Thursday, March 29, 2007 2:55 PM
To: 'verena.hawkes@us.army.mil'
Subject: CON-AK Open Imaging Center

Dear Ms. Hawkes,

Thank you for writing Governor Palin with your concerns regarding the Certificate of Need requirements, specifically related to Alaska Open Imaging Center in Fairbanks.

The Governor is also concerned about this issue and is working toward a review of the regulations surrounding the Certificate of Need program in order to resolve the issue, but may take time. Please be assured that it is not being ignored.

Anna Kim, Special Staff Assistant
Office of the Governor

Anna Kim

From: Governor Sarah Palin [governor@gov.state.ak.us]
Sent: Thursday, March 29, 2007 2:23 PM
To: verena.hawkes@us.army.mil
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Tuesday, March 27, 2007 1:16 PM
To: governor@gov.state.ak.us
Subject: Health_Care

Web mail from: Ms. Verena Hawkes
address: 1820 Kittiwake Drive Fairbanks AK 99709

MESSAGE:
Dear Governor Palin,

Please consider amending the Certificate of Need for the Alaska Open Imaging Center Fairbanks Clinic. I have used the clinic and was very impressed with the staff's friendly and caring attitude. I was treated with respect and dignity and my experience was definitely a positive one.

I went to the Fairbanks Center to get a second opinion. I had previously had an MRI done at another local facility for pain in my shoulder, and nothing showed up. But my problem didn't go away, my arm continued to hurt and was weak, so after several months I asked for a second MRI. It was suggested that I try the recently opened Alaska Open Imaging Center Fairbanks Clinic because it had a newer, larger magnet which should give a clearer picture. And sure enough, it did. What was previously missed due to a poor MRI picture was immediately visible on the MRI that was done at the Alaska Open Imaging Center Fairbanks Clinic. I subsequently underwent surgery for a torn rotator cuff, completed my physical therapy and am now working on strengthening my shoulder and a complete recovery is expected.

I shudder to think of what I would be going through if the Alaska Open Imaging Center Fairbanks Clinic had not been available. I would still have constant pain and limited use of my shoulder. And this is exactly why Fairbanks needs competition in the health care arena. Without it, there is no incentive for the existing health care providers to improve the quality of their service, hours, customer service, equipment, or facilities.

Governor Palin, please help allow health care competition in Fairbanks! Amend the Certificate of Need requirements and let the people of Fairbanks have a choice in their health care needs. Please help reopen the Alaska Open Imaging Center Fairbanks Clinic!

Thank you for your concern regarding this critical issue.

VERENA HAWKES
Concerned Citizen

erena.hawkes@us.army.mil

amd CON

VALLEY CHIROPRACTIC CLINIC, Inc.

Dr. James D. Martin
Chiropractic Physician

APR 23 2007

'Family Health Care Naturally'

April 12, 2007

1754
AK
Closed 4/25/07

Governor Sarah Palin
P.O. Box 110001
Juneau, AK 99801-0001

Dear Governor Palin:

The current situation regarding Certificate of Need and its effect on availability of independent imaging services such as MRI, Ultrasound, and CT scans outside of a hospital setting is a concern to me and others in my profession. As a health care provider it is imperative that varied avenues of diagnostic studies be readily available to my patients at an affordable price. Many times treatment is held off while objective findings are confirmed by securing an MRI or CT scan. Limited facilities result in decreased availability, diminished quality of service, and often become cost prohibitive to the patient.

Healthcare costs continue to rise in Alaska while a large number of our citizens are without health care coverage and many more are under insured. Alaska is a state that promotes growth and commerce while protecting our environment and maintaining personal freedom for its citizens. Yet, Alaska's Certificate of Need regulations are some of the most stringent in the nation. Many major hospitals in Alaska are using the Certificate of Need to monopolize healthcare availability and therefore dictating the cost of such services beyond feasibility for many of our citizens.

I believe competition is good for Alaska. Competition in healthcare promotes availability of services and raises quality of service to the people of Alaska as providers compete for patient loyalty. We need to amend the Certificate of Need in Alaska raising the limits to ensure a better future in healthcare for our citizens.

Sincerely,

James D. Martin, D.C., CCSP
Alaska Delegate American Chiropractic Association

400 N. Main - Wasilla, Alaska 99654 - (907) 373-2022 Fax (907) 373-2029

Con File repeal

response attached

Wade Hoek

From: Governor Sarah Palin [governor@gov.state.ak.us]
Sent: Friday, March 16, 2007 3:59 PM
To: grhyneer@pobox.mtaonline.net
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Thursday, March 15, 2007 4:04 PM
To: governor@gov.state.ak.us
Subject: Health_Care

Web mail from: Mr. george rhyneer Jr. M.D.
address: 3260 Providence Dr. Ste 200 anchorage AK 99508

MESSAGE:
Dear Gov. Palin,

The quality of healthcare is actually dropping in Alaska due to the fact that patients are required to go to certain hospitals and facilities due to backroom deals with insurance carriers. Having facilities compete and more of them will easily show this. People need to have choices. Many of the hospitals
already have monopolies and the CON law reinforces there ability to maintain the status quo. Excuses
made about the loss of private insured patients are just that. They don't want to see thier monopoly disappear. The people of Alaska are getting the short end of the stick. We, the physicians actually at the bedside see this daily. No hospital administrator... and I repeat this... no hospital administrator is working at night, at the bedside, in the operating rooms, in the imaging centers, with the nurses and physicians see this. They are big business...even when they say they are non profit. They are NOT long term forever alaskans. They will work here for 3-7 yea!
rs then move up the cooporate ladder.

My fellow physicians are Alaskans like you and here to stay. Get rid of that CON law!

sincerely and with respect. george rhyneer jr. orthopedic surgeon

grhyneer@pobox.mtaonline.net

Anna Kim

From: Anna Kim [anna_kim@gov.state.ak.us]
Sent: Saturday, March 17, 2007 1:20 PM
To: 'grhyneer@pobox.mtaonline.net'
Subject: CON Law

Dear Dr. Rhyneer,

Thank you for writing Governor Palin regarding the Certificate of Need law. She has asked that I respond to you directly.

Currently the department is evaluating these two legislative proposals. The Certificate of Need issue is very complex, and generally, a change to one part of the health care system will have an impact on other parts.

The State of Alaska takes an interest in the expenditure of public and private capital for health care facilities and services to further 3 public policy objectives: to 1) maintain access to health care, 1) assure high quality health care, and 3) contain health care costs.

As you may know, the Governor campaigned on a philosophy of support for more competition in health care services. As such, the official position of the administration is to support these bills as a way of bringing forth a discussion on how to best provide for more competition while maintaining these three policy objectives.

The certificate of need, for several years, has been one tool of several the state uses to achieve these goals. THE CON program is intended to promote responsible health facility and service development and to contain health care costs. Proposed projects are evaluated, using regulatory standards, to determine whether or not sufficient need exists in a community to support the addition of new health care facilities or services.

The department will work with legislators/stakeholders throughout the legislative process to evaluate the impact of the proposed legislation as it moves through the legislature. In addition, regardless of the outcome of the legislation this session, the Health Care Strategies Planning Council will likely consider this issue, among many other health care issues related to access, cost and quality of care. The Council will form this month and begin meeting shortly thereafter.
A report by the Council is due to the Governor on Jan. 1, 2008.

Thank you, Anna

Anna Kim, Special Staff Assistant
Office of the Governor

Anna Kim

From: Anna Kim [anna_kim@gov.state.ak.us]
Sent: Monday, February 26, 2007 3:18 PM
To: 'larrystinson@hotmail.com'
Cc: 'Wade_Hoek@gov.state.ak.us'
Subject: Certificate of Need

Larry,

Thank you for writing Governor Palin regarding CON issue.

I wanted to let you know that the administration will be addressing this highly visible issue. It will take time though, but will not be ignored.

Thanks, Anna

Anna Kim, Special Staff Assistant
Office of the Governor

Wade Hoek

From: Governor Sarah Palin [governor@gov.state.ak.us]
Sent: Monday, February 26, 2007 2:11 PM
To: 'Larry Stinson'
Subject: RE:

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

From: Larry Stinson [mailto:larrystinson@hotmail.com]
Sent: Monday, February 26, 2007 5:49 AM
To: kris_perry@gov.state.ak.us; sarah_palin@gov.state.ak.us; sean_parnell@gov.state.ak.us
Subject:

Governor and Lt. Governor:

AP report from February 21 titled "Economists: Health care expenses to grow" cites Federal Health and Human Services Secretary Mike Leavitt as saying "The only force strong enough to change the course of health care is a marketplace where consumers have the information and incentive to choose quality and keep costs low."

This is consistent with revising/removing CON restrictive, monopolistic trade practices and transparency in medical billing/costs.

Alaska needs a change.

Larry Stinson, M.D.

Find what you need at prices you'll love. Compare products and save at MSN® Shopping.

Savland, Monica L (GOV)

file
Pro Repeal

From: Governor Sarah Palin (GOV sponsored)
Sent: Tuesday, January 29, 2008 1:02 PM
To: snowball71@gci.net
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Tuesday, January 29, 2008 12:27 PM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Pro repeal CON

Web mail from: Ms. Jill Neff
address: PO Box 82464 Fairbanks AK 99708
907-488-4747

MESSAGE:
Dear Governor Palin,

I read today in the Fairbanks Daily News Miner with great disgust over Reps. Kelly and and Wilson opposition to removal of the CON. Apparently neither of these individuals have attempted to schedule a medical appointment in Fairbanks.

It is apparent that with Rep. Kelly's seat on the FMH foundation board, that he has an interest in keeping the CON in full force for the better of FMH but to the inconvenience of Fairbanks residents in need of medical care. His concern is that medical providers would be able to "cherry pick" medical services. That is already happening now. The clinics inform patients that a referral will have to be made to see if a case can be taken. Removing the CON will eliminate that "cherry picking". Competition is healthy. With Banner Health's purchase of Tanana Valley Clinic, it would appear that Fairbanks has a monopoly of health care developing.

The medical offices claim there is a shortage of doctors. If there is such a shortage (and there truly is), then the CON needs to be removed now. The interior needs more health care; not a noose tied around the necks of the residents.

The interior's harsh winters already puts Fairbanks at a disadvantage when trying to lure competent medical professionals to the Fairbanks North Star Borough. Many of these professionals who might be willing to brave our winter weather and open a practice then have to jump through hoops because of the CON and enormous pressure from Fairbanks Memorial Hospital. Given all that, why would any new doctors want to set up shop in Fairbanks?

I personally would rather see the residents of the interior receive quality medical care right here, in our community instead of having to travel to Anchorage, Seattle or beyond. Governor Palin, your statement that removing the CON would increase competition and decrease prices is correct. We would save on the cost of airfare!

We would also be able to receive quality medical care without having to wait 2 months for an appointment. The only other option is an urgent care facility or the hospital. Now isn't that convenient? The one entity (FMH) with the stroke to keep new medical care out is the one that directly benefits.

Thank you for your service and time.

Sincerely,
Jill Neff
Fairbanks

snowball71@gci.net

File
Doesn't Support Repeal
Supports Compromise

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Monday, February 11, 2008 7:51 AM
To: Thomas Imboden
Subject: RE:

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

From: Thomas Imboden [mailto:trigbay@starband.net]
Sent: Sunday, February 10, 2008 12:12 PM
To: Governor Sarah Palin (GOV sponsored)
Subject:

Thomas Imboden
P.O. Box 214
Gustavus, Alaska 99826
907 697.2425
trigbay@mail.com
February 7, 2008

Governor Sarah Palin
State Capital, third floor
Juneau, Alaska 99801
Governor@gov.state.ak.us

Dear Governor Palin:

Your recent State of the State speech provided numerous ideas for a comprehensive path for Alaska to follow in the twenty-first century. Included in your presentation, if I understand correctly, was a proposal to eliminate the Alaska Certificate of Need Program (CON). The focus of the following brief is imaging technologies and Ambulatory Surgical Centers (ASC). The following is submitted in response to your proposal.

The National Health Planning and Resources Act of 1974 provided the basis for the CON programs throughout the United States. The several states have had different experiences concerning the implementation and/or the abandonment of the program. Although implementation has fallen short of the ideal as manifested in the 1974 act the CON programs are valuable. As of 2004 there were thirty-six programs. Generally, the primary limitation of the efficacy of the program is the inherent politicalization and bureaucratization of the CON regulatory process. Mitigation of political intrusion within any given CON program is desirable, although total mitigation is not attainable. The process of the evaluation based on CON should go forward with the acknowledgement that politics will be a major component of the processes and that statesmanship is required. Costly expenditures and the expectation of significant financial rewards drive the political and medical economic processes. Also, bureaucratic processes have detrimentally influenced the implementation of the CON. Governmental activity in the health care industry, including the delivery of health care, is clearly in the interest of health care consumers. The action or non-action of the state will directly contribute to the overall cost of health care to the consumer. Those states that have abolished CONs have revisited the prudence of such actions.

There have been numerous studies of Certificate of Need. Some of the studies clearly show that CONs are

needed though some suggest that there are problems with how they have been implemented.[1] The primary issue to be asked in Alaska should be: What is best for the health care consumer? The Blue Cross Blue Shield Association commissioned a study concerning the efficacy of CONs[2].

The Blue Cross Blue Shield study found that Magnetic Resonance Imaging (MRI) and Computer axial tomography (CT, CAT) act as complements to one another. The increased availability of MRI and CAT are associated with an increase use with the other (vice versa) imaging technology. CAT and MRI imaging represent significant capital expenditures. Capital investment for a CT scanner typically runs 1.2 million dollars. Typical capital investment for a MRI scanner is 1.35 million dollars. (2005 dollars) The above capital outlay does not include installation and facility construction[3]. There are additional costs associated with advanced training of radiographers. Advanced training is required of the radiographer. Advanced training and certification will also increase the compensation package for the technician and thus the overall cost of each procedure. Decreased utilization of imaging machines, due to low geographic population densities, will also impact the cost per image.

Also troubling is the report by The American College of Radiology "that the majority of diagnostic imaging examinations performed outside hospitals in the United States are not performed by radiologists[4] and that in recent years, there has been a sticking increase in the number of complex, high-cost imaging exams performed by nonradiologists as compared to those performed by radiologists.[5] "Overall, the utilization rate of advanced, high-technology imaging is increasing among both radiologists and nonradiologists. However, it is *increasing* at a considerably more rapid rate among *nonradiologists*."[6] (Italics added)

Commercial and Medicare Part B beneficiaries may be subject to over utilization of non-invasive diagnostic imaging (NDI) services. Currently, Medicare beneficiaries must meet their annual deductible and their twenty percent co-insurance (co-pay) for out-patient services. Generally, those with Medicare Part B benefits have a lower disposable income level which predisposes them to a health care delivery deficit and financial hardship. In addition, elderly beneficiaries often acquiesce to the recommendation and authority of their physician(s) without due reflection of the alternatives presented and thus the overall benefits to be achieved. The scenario(s) as presented in the mass media strongly suggests that technology is the panacea for the majority, if not all, of medical ills, rather than relaying on the art of medicine by the practitioner and long established technologies.

Studies of non-imaging technologies e.g., percutaneous transluminal coronary angioplasty, indicate that availability (or scarcity of facilities) and overall cost is not a significant factor. Studies have been completed, that included CMS beneficiaries, which would support a free market approach for those procedures. This would support the argument that current technologies that require a CON prior to construction and/or implementation need not be included in a reform CON "package". However, judicious examination of the specific technology should be done prior to their elimination from any CON process.

Other areas of responsibility of the CON process are construction authorization of new health facilities and modernization of existing hospital facilities. The CON is intended to eliminate unnecessary duplication of existing health care service facilities and thus reduce overall health care costs. Many states have found that traditional full service hospitals are compromised in their mission due to several factors including competition with Ambulatory Surgical Centers and specialty hospitals. Many communities have found that the traditional full service hospital has been replaced by specialty hospitals. Mr. Gary Barnett testified before the Illinois Health Facilities Planning Board on February 22, 2007. His testimony included the following: "When I moved from Kansas to Illinois in1998, there were two full service hospitals in the city of Wichita, Kansas. Between 1999 and 2003, two heart hospitals, one spine hospital, and two surgical hospitals opened. Today, Wichita, with a population of 530,000 people, has 2 full service hospitals, 2 heart hospitals, 1 spine hospital, 2 surgical hospitals, 8 ambulatory surgery

PREPARED STATEMENT OF
THE FEDERAL TRADE COMMISSION

Before the

STANDING COMMITTEE on HEALTH, EDUCATION & SOCIAL SERVICES

of the

ALASKA HOUSE OF REPRESENTATIVES

on

House Bill 337, "An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; relating to the certificate of need program for certain health care facilities; and providing for an effective date."

February 15, 2008

I. Introduction

The Federal Trade Commission (FTC) is pleased to have the opportunity to discuss health care competition, Alaska's certificate of need (CON) laws, and Alaska House Bill 337 (H.B. 337), which would modify certain of Alaska's CON laws.[1] The Commission believes that CON laws such as Alaska's can be a barrier to entry to the detriment of health care competition and health care consumers, and that the legislature should consider their repeal. The Commission's conclusion is based on the joint FTC/Department of Justice (DOJ) report, *Improving Health Care: A Dose of Competition* (Report or FTC/DOJ Report),[2] its underlying research, and recent work by FTC staff and the staffs of our sister agencies, such as DOJ and the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services. As noted in the FTC/DOJ Report, "[t]he Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[3]

Congress has charged the Commission with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[4] Pursuant to its statutory mandate, the FTC seeks to identify business practices and regulations that

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[1] The FTC initially was invited to submit testimony regarding H.B. 337, as introduced on January 22, 2008, which would have repealed Alaska's CON requirements generally, a more recent committee substitute draft also before the relevant Alaska house committee (but not yet available publicly) would repeal only certain of Alaska's CON requirements, but leave others – such as those regarding nursing homes – intact

[2] FEDERAL TRADE COMMISSION & THE DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July, 2004) [hereinafter "IMPROVING HEALTH CARE"].

[3] *Id.* at Executive Summary, p. 22.

[4] Federal Trade Commission Act, 15 U.S.C. § 45.

impede competition without offering countervailing benefits to consumers. For several decades, the FTC and its staff have investigated the competitive effects of restrictions on the business practices of health care providers.[5] Included in that general body of health care competition work have been hearings, studies, and reports addressing issues raised by CON laws.

Specifically, the FTC/DOJ Report discusses critically the role of CON laws in health care competition, both as a distinct policy issue and as an important component of other health care competition issues, such as entry problems in hospital markets. The Report broadly examined the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying the preferences of Americans for high-quality, cost-effective health care. The Report was based on, among other things, joint FTC/DOJ hearings that took place over 27 days from February through October 2003, following a Commission-sponsored workshop on health care issues in September 2002. The FTC and DOJ heard testimony from about 240 panelists, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from antitrust and economics to health care quality and informed consent. Together, the hearings and workshop elicited written submissions from interested parties. Almost 6,000 pages of transcripts of the hearings and workshop and all written submissions are available on the Commission website, www.ftc.gov. In addition, FTC and DOJ staffs undertook independent research for the Report.

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[5] *See* Federal Trade Commission, *FTC Antitrust Actions in Health Care Services and Products* (Oct. 2003), *available at* http://www.ftc.gov/bc/hcupdate031024.pdf

In this testimony, the Commission focuses specifically on a few of the issues discussed in the Report that address CON laws and new entry into competition among health care facilities. Three main points require attention:

- First, vigorous competition among healthcare providers, such as hospitals, clinics, and nursing homes, usually benefits consumers through better and more varied services and, in some cases, lower prices. CON laws were designed to create barriers to entry for new healthcare facilities or providers to contain the costs of healthcare services. CON laws, however, have not been particularly effective in controlling healthcare costs, while posing significant risks to competition. In particular, CON laws can retard the entry of firms that could provide higher quality services or lower prices than those offered by incumbents, depress consumer choice between qualitatively different treatment options or settings, or reduce the pressure on incumbents to improve qualitative aspects of their own offerings. Policymakers would be wise to consider reviewing all of the actual costs, benefits, and consequences – intended and unintended – of a regulatory system when assessing that system's future.
- Second, the CON regulatory system creates both the incentive and means by which an incumbent healthcare provider can use the regulatory system itself to delay effective competition, independent of the demand for additional healthcare services. This additional loss of competition is another regulatory cost that must be weighed in the balance when assessing the public interest.

- Finally, Alaska currently has one of the most stringent CON laws in the United States. House Bill 337's proposed amendment of this law would eliminate or reduce barriers to entry for a broad range of healthcare service providers, including small entities that might then be able to thrive as never before.

These points are addressed more fully, below.

II. Discussion

A. Provider Competition Generally: Competition has important benefits in health care services markets, just as it has in the multitude of markets in the U.S. economy that rely on competition to maximize the welfare of consumers. Competitive pressures can lead hospitals and other entities to lower costs, improve quality, and compete more efficiently. In particular, competitive pressure may spur new types of competition. In some hospital markets, new entrants specialize and provide only a limited portion of the in-patient and out-patient services that general hospitals tend to provide.[6] Elsewhere, health care services once delivered only in large hospitals – and requiring overnight stays – may be performed more conveniently and less invasively, at lower cost, in outpatient settings. In addition, both traditional providers and new entities have explored new means to expand access to basic health care by, for example,

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[6] *See generally Prepared Statement of the Federal Trade Commission, Before the S. Subcomm. On Federal Financial Management, Gov't Information and Int. Security of the S. Comm. on Homeland Security and Governmental Affairs, on New Entry Into Hospital Competition* (May 24, 2005) (regarding, e.g., new specialty hospital entry), *available at* http://www.ftc.gov/os/2005/05/052405newentryintohospitalcomp.pdf; *see also* UNITED STATES DEPT. OF HEALTH AND HUMAN SERVICES, FINAL REPORT TO THE CONGRESS AND STRATEGIC IMPLEMENTING PLAN REQUIRED UNDER SECTION 5006 OF THE DEFICIT REDUCTION ACT OF 2005 (2006) [hereinafter "HHS FINAL REPORT"], *available at http://www.cms.hhs.gov/PhysicianSelfReferral/06a_DRA_Reports.asp.*

establishing limited service clinics that can provide more convenient and lower cost care and bring more consumers into contact with the larger health care system.[7]

Although new strategies for lowering costs and enhancing quality are emerging, competition is not as effective as possible in most health care markets, because the prerequisites for competitive markets are not fully satisfied. Of particular concern for today's purpose is the extent to which state regu tions can create barriers to entry in health care markets, without conferring countervailing benefits in quality of care or cost containment.[8]

At the same time, the empirical evidence generally does not indicate that CON laws control health care costs.[9] Recent broad studies analyzing both national and state

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[7] *See, e.g.*, FTC Staff Comment Before the Massachusetts Department of Public Health Concerning Proposed Regulation of Limited Service Clinics, 1-2 (Oct. 2007)

[8] In discussing competition concerns raised by CON requirements, the Commission does not mean to suggest that state CON regulations are the only regulatory impediments to competitive forces in health care markets. For example, in testimony before the House Committee on Energy and Commerce on May 12, 2005, Mark McClellan, then Administrator of CMS, reported that CMS, following its own study of specialty hospitals pursuant to congressional direction, would analyze and reform its payment rates "to help reduce the possibility that specialty hospitals may take advantage of imprecise payment rates in the inpatient hospital prospective payment system" and "to diminish the divergences in payment levels [for ambulatory surgical centers] that create artificial incentives for the creation of small orthopedic or surgical hospitals." *Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, Before the H. Comm. on Energy and Commerce Hearing, "Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care,"* (May 12, 2005), *available at* http://www.hhs.gov/asl/testify/t050512.html; *see also Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, on Physician-Owned Specialty Hospitals Before the S. Finance Comm.* (May 17, 2006), *available at http://www.hhs.gov/asl/testify/t060517b.html*

[9] IMPROVING HEALTH CARE, *supra* note 2, at C. 8, at pp. 1-6. Although the larger body of CON literature – including anecdotal reports and small, uncontrolled studies – presents somewhat mixed conclusions on cost savings, the conclusions of the FTC/DOJ Report and staff research have substantially been borne out by more recent, sophisticated large-scale data analyses and literature reviews: "[O]n balance, the most methodologically sound studies have found that CON has no effect or actually increases both hospit spending per capita and total spending per capita." CHRISTOPHER J. CONOVER & FRANK A. SLOAN, EVALUATION OF CERTIFICATE OF NEED IN MICHIGAN, CENTER FOR HEALTH POLICY, LAW AND MANAGEMENT, TERRY SANFORD INSTITUTE OF PUBLIC POLICY, DUKE UNIVERSITY, A REPORT TO THE MICHIGAN DEPT. OF COMMUNITY HEALTH, 30 (May 2003) (reviewing literature and discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws) (hereinafter "CONOVER & SLOAN, REPORT TO MICHIGAN"); WASHINGTON STATE JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE (JLARC), EFFECTS OF CERTIFICATE OF NEED AND ITS POSSIBLE REPEAL, 1 (Jan. 8, 1999) ("The study found that CON has not controlled overall health care spending or hospital costs.

data reveal "little evidence that CON results in a reduction in costs and some evidence to suggest the opposite."[10] Studies also fail to show any consistent increase or surge in health care spending when states remove or modify their CON requirements.[11]

Barriers to entry can affect qualitative competition as well. As the Report noted, state CON laws can retard the entry of firms that could provide higher quality services than those offered by incumbents.[12] That may tend to depress consumer choice between qualitatively different treatment options or settings,[13] or it may reduce the pressure on incumbents to improve qualitative aspects of their own offerings.

The study generally found either conflicting or limited evidence about the effects of CON on the cost of non-hospital services, and on the quality and availability of the various health care services.") DANIEL SHERMAN, FEDERAL TRADE COMMISSION, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS, iv, 58-60 (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data on 3,708 hospitals, that strong CON programs do not lead to lower costs but may actually increase costs); MONICA NOETHER, FEDERAL TRADE COMMISSION, COMPETITION AMONG HOSPITALS 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); KEITH B. ANDERSON & DAVID I. KASS, FEDERAL TRADE COMMISSION, CERTIFICATE OF NEED REGULATION OF ENTRY INTO HOME HEALTH CARE: A MULTI-PRODUCT COST FUNCTION ANALYSIS (1986) (economic study finding that CON regulation led to higher costs, and that CON regulation did little to further economies of scale). *But c.f.*, COMMONWEALTH OF VIRGINIA, REPORT OF THE JOINT COMMISSION ON HEALTH CARE, HOUSE DOC. NO. 82, STUDY OF VIRGINIA'S CERTIFICATE OF PUBLIC NEED (COPN) PROGRAM PURSUANT TO HB 1302 OF 1996 (1997), ("There is little evidence of significant COPN impact on aggregate health expenditures, but there is evidence of savings for specific services covered by COPN"). *Id.* at 1, *available at* http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD821997/$file/HD82_1997.pdf?bcsi_scan_129F6A3CDB83467E=xLesgwMDZ3sPV18TFUnlHEOAAAD+O30W&bcsi_scan_filename=HD82_1997.pdf (last checked 1/31/08).

[10] CONOVER & SLOAN, REPORT TO MICHIGAN, *supra* note 9 at vii (discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws); *id.* at 30-31.

[11] CONOVER AND SLOAN also report that, "[i]n most states that lifted CON, per capita spending on hospital and physician services (relative to the US) has remained below the U.S. average following removal of CON.") *Id.* at 50; *see also* Christopher J. Conover and Frank A. Sloan. *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL'Y & LAW 455 (1998) ("no evidence of a surge in acquisition of facilities or in costs following removal of a CON.") 458.

[12] IMPROVING HEALTH CARE, *supra* note 2, at C. 8, p. 4 (citing Hosp. Corp. of Am., 106 F.T.C. 361, 495 (1985) (Opinion of the Commission) (stating that "CON laws pose a very substantial obstacle to both new entry and expansion of bed capacity in the Chattanooga market" and that "the very purpose of the CON laws is to restrict entry").

[13] With regard to hospital markets, *see, e.g.*, HHS FINAL REPORT, *supra* note 6, at 10 (reporting "quality of care at least as good as, and in some cases better than, care provided at local competitor hospitals" for

B. Incumbent Lobbying and Petitioning Protections: When new firms threaten to enter a market, incumbent firms may seek to deter or prevent that new competition. Such conduct is by no means unique to health care markets; it is a typical reaction of incumbents to possible new competitors. In certain circumstances, such conduct may violate the antitrust laws.[14] Certain anticompetitive conduct may, however, be shielded from antitrust scrutiny. The *Noerr-Pennington* doctrine immunizes from antitrust liability conduct that represents petitioning the government, even when such petitioning is done "to restrain competition or gain advantage over competitors."[15] Moreover, the state action doctrine shields from antitrust scrutiny many of a state's own activities when a state government is acting in its sovereign, legislative capacity.[16]

In the context of health care competition, the combination of these two doctrines can offer antitrust immunity to providers that wish to lobby state officials to impede the entry of potential competitors, by denying or delaying the CONs required for operation. State CON programs generally prevent firms from entering certain areas of the health

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cardiac care, as well as "very high" patient satisfaction in cardiac hospitals and orthopedic specialty hospitals) (citations omitted). In addition, specialty hospitals appear to offer shorter lengths of stay, per procedure, than peer hospitals. *See* MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS, 15-17 (Mar. 2005) (hereinafter MEDPAC REPORT). MedPAC was directed to report to Congress on certain issues regarding specialty hospitals under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. *Id.* at vii.

[14] *See* IMPROVING HEALTH CARE, *supra* note 2, at 15-16, ch 1, at 31-33, ch.3, at 22-27.

[15] Andrx Pharm. V. Biovail, 256 F.3d 799, 817 (D.C. Cir. 2001), *cert. denied*, 122 S. Ct. 1305 (2002). The doctrine is named for the seminal cases that treated it: Eastern R.R. Presidents Conference v. Noerr, 365 U.S. 127 (1961), and United Mine Workers v. Pennington, 381 U.S. 657 (1965).

[16] Parker v. Brown, 317 U.S. 341, 351 (1943). The state action doctrine also immunizes from antitrust scrutiny the actions of other entities and individuals if they are acting in furtherance of a clearly articulated state policy and are actively supervised by the state. *See, e.g.*, California Retail Liquor Dealers Assn. v. Midcal Aluminum, 445 U.S. 97, 105 (1980).

care market unless they can demonstrate to state authorities an unmet need for their services. Because that demonstration can be time-consuming and costly, it may delay or, at the margin, prevent the introduction of certain needed facilities and services.[17] Indeed, limiting competitor entry and raising competitors' costs may both be incentives for incumbents to seek to abuse the regulatory process. The FTC/DOJ Report concluded that "incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market."[18] To the extent they are successful in doing so, incumbents may preserve their market shares and revenue streams without enhancing their own operating efficiency or providing health care savings to the state or its consumers.[19]

C. **The Scope of Alaska CON Law:** Alaska's current CON law is among the most stringent of such laws in the United States. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974,[20] which offered states powerful incentives to enact laws implementing CON programs.[21] By 1980, all states except Louisiana had done so.[22]

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[17] *See e.g.*, IMPROVING HEALTH CARE, *supra* note 2, at C. 4, p. 25 (noting that approval of a CON "can take anywhere from 18 months to several years," and that regulatory delays from CON approval are in addition to those imposed by, for example, traditional licensing requirements).

[18] *Id. at* Exec. Summ., at 22.

[19] *See, e.g.*, MEDPAC REPORT at 10-11 ("Some community hospital administrators admit that competition with specialty hospitals has had some positive effects on community hospitals' operations").

[20] Pub. L. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k-300n-5), *repealed*, Pub. L. 99-660, § 701, 100 Stat. 3799 (1986).

[21] *See* JOHN MILES, 2 HEALTH CARE & ANTITRUST LAWS: PRINCIPLES & PRACTICE § 16:1, at 16-2 (2003) (noting that the federal Health Planning Act required providers to "obtain state approval – a 'certificate of need' – before spending set amounts on capital investments or adding new health care services.")

[22] *See, e.g.*, *On Certificate of Need Regulation: Hearing on H.B. 332 Before the Senate Comm. On Health and Human Services* (Ohio 1989) (Statement of Mark D. Kindt, FTC Regional Director).

Congress repealed the federal law in 1986, however, and many states have repealed or revised their CON laws in the years since. Fourteen states have eliminated their CON requirements altogether[23] and, although a substantial number of states continue to maintain CON programs,[24] they do so "often in a loosened form compared to their predecessors."[25] Remaining CON laws may address only specific types of health care facilities – such as hospitals or nursing homes,[26] – exempt certain types of health care facilities,[27] or apply broadly to health care facilities improvements of a greater magnitude.[28] In addition, certain CON laws may be pending repeal according to a sunset provision.[29]

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[23] *See, e.g.*, National Conference of State Legislatures, *Certificate of Need: State Health Laws and Programs* (updated Nov. 2007) (CON laws repealed or not in effect in CA, AZ, NM, TX, KS, CO, UT, WY, ID, SD, ND, MN, IN, and PA), *available at* http://www.ncsl.org/programs/health/cert-need.htm (last checked 01/25/08).

[24] MILES, *supra* note 21, § 16:2, at 16-9 (stating that "CON laws remain in many states and the District of Columbia"). Quite recently, Florida exempted from CON requirements new adult open-heart surgery and angioplasty programs at general hospitals and the addition of beds to existing hospital structures. Fla. Bill SJ 01740 (effective July 1, 2004), *amending* FLA STAT. ch. 408.036, .0361 (2003).

[25] MILES, *supra* note 21, § 16:1, at 16-2 to 16-3. *See also* Len M. Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning*, 23 HEALTH AFFAIRS 1, 11 (Mar./Apr. 2004) (noting that CON programs "eroded through the 1990s").

[26] *See, e.g.*, OAC Ann. 3701-12-05 (2007) (regarding only certain activities by "long-term care" facilities in Ohio); R.R.S. Neb. § 71.5829.03 (2007) (CON covers only certain activities related to long-term care and rehab beds in Nebraska); ORS § 442.315(1) (2005) (regarding "any new hospital or new skilled nursing or intermediate care service or facility" in Oregon, subject to certain exclusions).

[27] For example, Connecticut law exempts critical access hospital beds and related equipment from the State's CON laws. *See* Conn. Gen. Stat. § 19a-487a (2007); *see also* Fla. Stat. § 408.0361 (2007) (regarding cardiovascular services and burn unit licensing), Fla. Stat. § 408.036 (2007).

[28] For example, Connecticut health care facilities must obtain a CON prior to developing, expanding or closing certain services and expending more than $3 million on a capital project. Conn. Gen. Stat. § 19a-638(a)(4) (2007); Delaware requires a CON for the establishment of a new facility, but only for capital expenditures by existing facilities in excess of $5.8 million (or a higher amount based on inflation adjustments to the $5.8 million baseline). *See* 16 Del. C. § 9304 (2007).

[29] *See, e.g.* 16 Del. C. § 9311 (2007) (sunset provision).

Alaska law requires a CON for any type of health care facility construction or improvement of $1,000,000 or more, adjusted,[30] or the establishment of a nursing home facility independent of that cost threshold.[31] In so doing, it places significant regulatory burdens on the development or improvement of a very broad class of health care facilities – not just major hospital initiatives and expansions, which may be subject to long-term planning – but diverse outpatient clinic initiatives, which might otherwise develop dynamically in response to market needs. The scope of current Alaska law thus stands in contrast not only to the laws of those states that have eliminated their CON requirements altogether, but the laws of the many states that have more limited CON requirements. Alaska's low CON threshold itself may be a special burden to the State's health care spending, as low CON thresholds have been observed to increase costs – relative to higher thresholds – rather than decrease them.[32]

A degree of controversy may remain about particular issues addressed by certain CON laws. These include, for example, efficiency and possible conflicts of interest concerns about certain categories of physician-owned specialty hospitals and access issues for rural or other underserved areas.[33] However, the sweep of Alaska's CON law

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[30] Alaska Stat. § 18.07.031(a) (2007). The statute contains an adjustment provision, whereby the $1 million dollar threshold may be increased by $50,000 per anum, between 2005 and 2014. *Id.* at § 18.07.031(d).

[31] *Id.* at § 18.07.031(b).

[32] *See* SHERMAN, *supra* note 9, at 58-60 (1.4 percent decline in costs associated with doubling of all thresholds).

[33] *See, e.g.*, Testimony of Mark B. McClellan, M.D., Ph.D. (2005), *supra* note 8; Testimony of Mark B. McClellan, M.D., Ph.D. (2006), *supra* note 8 (regarding CMS studies of physician-owned specialty hospitals, implementation and termination of limited moratorium on new specialty hospitals). The Commission does not here intend to analyze the details of ongoing regulatory reform at CMS designed to address special concerns about certain limited types of specialty hospitals (and related physician self-referral issues) or the various bodies of research on which those reforms are based. The FTC notes, simply,

is much broader than required to address any of those more narrow and complex issues and is likely to be detrimental to Alaska's health care consumers. The Commission recommends that Alaska carefully consider the evidentiary basis of these issues as they may relate to Alaska health care consumers. If the evidence and public policy considerations warrant some legislative action, the Commission recommends that Alaska consider regulation that is narrowly tailored to achieve focused health policy goals instead of broad regulation of entry into the market for health care facilities.

III. Conclusion

CON laws were adopted throughout most states under particular market and regulatory conditions substantially different from those that predominate today and were intended to help contain health care spending. The best available research does not support the conclusion that CON laws actually reduce such expenditures. As the FTC and DOJ have said, "on balance, CON programs are not successful in containing health care costs, and ... they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[34] CON laws tend to create barriers to entry for health care service providers who may contribute to qualitative competition and provide consumers with important choices in the market, but CON laws do not, on balance, tend to suppress health care costs or aggregate health care spending. Moreover, CON laws may be especially subject to abuse by incumbent providers, who can seek to exploit a state's CON process to forestall the entry of competitors in their markets.

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that most of the actual and potential health care entities subject to Alaska CON law are not such specialty hospitals and appear to fall outside the concerns driving those studies and reforms.

[34] IMPROVING HEALTH CARE, *supra* note 2, at Executive Summary, p. 22.

Alaska's current CON law – which House Bill 337 seeks to modify – is among the most stringent of such laws in the United States. As a consequence, Alaska CON law creates a barrier to entry for a very broad range of health care service providers, including small health care entities that may be ill-equipped to overcome it. The Commission believes that both the breadth of Alaska's CON law, and its low threshold, are of special concern, as they may work to the detriment of Alaska health care consumers. In the event that adequate evidence develops to support more narrow policy priorities, the Commission believes that Alaska should consider regulations narrowly tailored to meet those priorities, while minimizing the general costs to Alaska health care consumers.

Competition in Healthcare and Certificates of Need

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January 31, 2008[1]

Good afternoon. I appreciate the invitation to the Antitrust Division of the U.S. Department of Justice to share our views on the impact of Certificate of Need ("CON") laws on healthcare markets.

My name is Joseph Miller. I am the Assistant Chief of the Litigation I Section of the Antitrust Division. The Litigation I Section enforces the antitrust laws in a wide variety of industries, including healthcare markets. Our attorneys confer closely with a large team of economists holding doctorates in the study of markets and their performance, including a number with specialization in the performance of healthcare markets. We also confer closely with the attorneys and economists at the Federal Trade Commission, who have dedicated time to the study of healthcare markets.

The Antitrust Division and the FTC have investigated and litigated antitrust cases in markets across the country involving hospitals, physicians, ambulatory surgery centers, stand-alone radiology programs, medical equipment, pharmaceuticals and other healthcare products. Through that work we have developed a substantial understanding of the competitive forces that drive innovation in and contain the costs of healthcare. We regularly issue informal advisory letters on the application of the antitrust laws to healthcare markets, and periodically issue reports and general guidance to the healthcare community. For example, in 2003, we conducted 27 days of hearings on competition and policy concerns in the healthcare industry, heard from approximately 250 panelists, elicited 62 written submissions, and generated almost 6,000 pages of transcripts.[2] As a result of that effort, we published an extensive report, entitled *Improving Health Care: A Dose of Competition*, in July 2004.

I. Scope of Remarks

The Antitrust Division's experience and expertise has taught us that Certificate of Need laws pose a substantial threat to the efficient performance of healthcare markets. By their very nature, CON laws create barriers to entry and expansion and thus restrict free and open

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[1] This paper draws significantly from testimony delivered on behalf of the Antitrust Division to the General Assembly and Senate of the State of Georgia on February 23, 2007.

[2] This extensive hearing record is largely available at http://www.ftc.gov/bc/healthcare/research/healthcarehearing.htm.

competition. They undercut consumer choice, weaken markets' ability to contain healthcare costs, and stifle innovation.

We have examined historical and current arguments for CON laws, and conclude that such arguments provide no economic justification for depriving consumers' of the benefits of free markets. To the extent that CONs are used to further non-economic goals, they impose substantial costs. Such goals, purportedly furthered through CON laws, can be more efficiently achieved through other mechanisms. We hope you will carefully consider the substantial costs that CON laws impose on consumers as you evaluate whether to eliminate those laws in Alaska.

I do not testify today to discuss the details of the legislation you are considering. I am, however, generally familiar with the issues before you and recognize them as issues that CON laws present in other states and other markets. My remarks, accordingly, will focus on the impact of and justifications for CON laws generally.

It is not the Antitrust Division's intent to "favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, [our] goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices . . ."[3] Our overall mission is to preserve and promote economic competition rather than to preserve any particular marketplace rival or group of rivals.

II. Importance of Competition and the Harm Caused by Regulatory Barriers to Entry

A. The Benefits of Competition in Healthcare

Our concerns about the harm from CON laws are informed by one fundamental principle: market forces improve the quality and lower the costs of healthcare services. They drive innovation and ultimately lead to the delivery of better healthcare. Government intervention can undermine market forces to the detriment of healthcare consumers.

In our antitrust investigations we often hear the argument that healthcare is "different" and therefore competition principles do not apply to the provision of healthcare services. The proposition that competition cannot work in healthcare is simply not true. Engineers and lawyers have made similar arguments that competition does not work in their industries and, in fact undermined other social goods advanced by their professions. Such arguments have been rejected by the courts, and private restraints on competition have long been condemned.[4] Indeed, at least since the Supreme Court's seminal 1943 decision in a case brought by the Department of Justice against the American Medical Association, competition has played a critical role in

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[3] Statements of Antitrust Enforcement Policy in Health Care, August 1996, Introduction, pg. 3 (available at: http://www.usdoj.gov/atr/public/guidelines/1791.htm).

[4] *F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990); *National Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978).

shaping the delivery of healthcare in this country.[5] The Antitrust Division and the Federal Trade Commission have worked diligently to make sure that private barriers to that competition do not arise.

During our extensive healthcare hearings in 2003, we obtained substantial evidence generally about the role of competition in our healthcare delivery system and reached the conclusion that vigorous competition among healthcare providers "promotes the delivery of high-quality, cost-effective healthcare." Specifically, competition results in lower prices and broader access to health care and health insurance, while non-price competition can promote higher quality.[6]

This finding is not new. We saw in the 1990s the growth of managed care and the impact it had on the cost and availability of insurance. Competition among and between hospitals and physicians intensified with the development of managed care organizations. In addition to putting pressure on costs, managed care plans have pressured providers to use shorter hospital stays and to offer alternative outpatient treatments. This evolution in health care purchasing led to lower costs and increased choice without sacrificing quality. Moreover, lower costs and improved efficiency made health insurance more affordable and available.

Competition also helped bring to consumers important innovations in healthcare technology. For example, health plan demand for lower costs and "patient demand for a non-institutional, friendly, convenient setting for their surgical care" drove the growth of Ambulatory Surgery Centers (ASCs).[7] Ambulatory surgery centers offered patients more "convenient locations, shorter wait time, and lower coinsurance than a hospital department."[8] Important to the success of these competitive forces in improving the delivery of care to consumers was the availability of technological advances, such as endoscopic surgery and advanced anesthetic agents.[9] Thus, competition harnessed this new technology and brought it to consumers in the lower cost, more convenient setting of ambulatory surgery centers. The impact on traditional general acute care hospitals led to those hospitals responding to the competition by delivering more care, in a better manner, in an outpatient setting, both at their own campuses and at ambulatory surgery centers in which they invested.

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[5] *American Medical Association v. U.S.*, 317 U.S. 519, 529 (1943).

[6] *Improving Health Care: A Dose of Competition*, ch. 3 § VIII and Executive Summary at 4 (July 2004) available at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf. ("*A Dose of Competition*").

[7] Id., Ch. 3 at 25.

[8] Medicare Payment Advisory Commitions (MedPAC), Report to the Congress: Medicare Payment Policy § 2F, at 140 (2003), available at http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf.

[9] A Dose of Competition, at ch. 3 at 24.

This type of competitive success story has occurred again and again in healthcare in the area of pharmaceuticals, urgent care centers, and elective surgeries such as Lasik procedures, to name just a few. Without private or governmental impediments to their performance, we can expect healthcare markets to continue to deliver these benefits.

B. CON Laws Create Barriers to Beneficial Competition

CON laws are a classic government-erected barrier to entry, and by their nature are an impediment to the proper functioning of the market process. Accordingly, in *A Dose of Competition*, the Federal Trade Commission and we urged the states to rethink their CON laws.[10]

1. Original Cost-Control Reasons For CON Laws No Longer Apply

We made that recommendation in part because the original reason for the adoption of CON laws is no longer valid. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974, which offered incentives for states to implement CON programs. At the time, the federal government and private insurance reimbursed healthcare charges predominantly on a "cost-plus" basis, which provided incentives for over-investment. The hope was that CON laws would provide a counterweight against that skewed incentive.

In considering this historical justification for CON laws, we need to keep clear that a number of other arguments made today in support of CON laws were not part of the rationale for their original adoption –

* CON laws were not adopted as a means of cross-subsidizing care;

* CON laws were not adopted in order to have centralized planning of the location and nature of healthcare facilities; and,

* CON laws were not adopted to protect the health and safety of the population from poor quality medicine.

Instead, CON laws were adopted because excessive capital investments, spurred by the then-current cost-plus method of reimbursement, were driving up healthcare costs. There was concern that, because patients are usually not price-sensitive, providers engaged in a "medical arms race" by unnecessarily expanding their services to offer the perceived highest quality services.[11]

CON laws appear to have failed in their intended purpose of containing costs. Several studies have examined the effectiveness of CONs in controlling costs. The empirical evidence

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[10] *A Dose of Competition*, Executive Summary at 22.

[11] *A Dose of Competition*, Ch. 8, pg. 1-2.

on the economic effects of CON programs has demonstrated near-universal agreement among health economists that CON laws were unsuccessful in containing healthcare costs.[12]

In addition to the fact that CON laws have been ineffective in serving their original purpose, CON laws should be reexamined because the reimbursement methodologies that may in theory have justified them initially have changed significantly since the 1970s. The federal government no longer reimburses on a cost-plus basis. In 1986, Congress repealed the National Health Planning and Resources Development Act of 1974. Additionally, health plans and other purchasers routinely bargain with healthcare providers over prices. Essentially, government regulations have changed in a way that eliminates the original justification for CON programs.[13]

2. Protecting Revenues of Incumbents Does Not Justify CON Laws

Incumbent hospitals often argue that they should be protected against additional competition so that they can continue to cross-subsidize care provided to uninsured or under-insured patients. Under this rationale, CON laws would impede the entry of such healthcare providers as independent ambulatory surgery centers, free-standing radiology or radiation-therapy providers, single- or multi-specialty physician-owned hospitals, because if these new competitors were to enter the marketplace, community hospitals could not continue to exploit their existing market power over consumers. Put another way, without CON laws, we would see new, higher-quality, low cost providers in the marketplace, which would put competitive pressure on incumbent providers, and deprive them of revenues they could put to a charitable use.[14]

We fully appreciate the laudatory goal of providing sufficient funding for community hospitals so that these hospitals can provide healthcare services to those who cannot afford them and for whom government payments are either unavailable or too little to cover the cost of care. But, we also want to make clear that the use of government barriers to entry to fund indigent care has costs. There are more efficient ways to accomplish this goal without incurring the costs of impeding the proper functioning of health care markets. Essentially, by protecting incumbent hospitals from competition, CON laws allow dominant hospitals to tax consumers through the exercise of market power in order to pursue the charitable goal of providing care to other, less fortunate consumers. In using that funding mechanism, however, the CON laws may do more harm than good.

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[12] David S. Salkever, Regulation of Prices and Investment in Hospital in the United States, in 1B Handbook of Health Economics, 1489-90 (A.J. Culyer & J.P. Newhouse eds., 2000) ("there is little evidence that [1970's era] investment controls reduced the rate of cost growth.")

[13] *A Dose of Competition* at pg. 1-6.

[14] Note the irony of this argument: What started as laws intended to control costs have become laws intended to inflate costs. Proponents of CON laws now would use these barriers to entry to stifle competition, protect incumbent market power, frustrate consumer choice, and keep prices and profits high.

First, CON laws harm the consumers who would have chosen alternative, lower priced, higher quality, or more convenient sources of care.

Second, CON laws impose that cost without any clear evidence that other desirable social goals are advanced. The evidence to date indicates that new competition does not undercut community hospitals' ability to fulfill charitable missions. Recently the federal government studied just this issue in connection with the emergence of single-specialty hospitals around the country. The study found that, for several reasons, specialty hospitals did not undercut the financial viability of rival community hospitals.[15] One substantial reason for this was that specialty hospitals generally locate in areas that have above average population growth. Thus, they are competing for a new and growing patient population, not just siphoning off the existing customer base of the community hospitals.

Third, new competition can force community hospitals to improve their performance. In studying the effect of single-specialty hospitals, MedPAC found that the community hospitals responded to the competition by improving efficiency, adjusting their pricing, and expanding profitable lines of business.[16] Community hospitals encouraged physicians to perform procedures on the hospital campus by developing centers of excellence and building physician offices on campus.[17] Overall, community hospitals affected by specialty hospital entry maintained profit margins in line with national averages. Rather than undercutting community hospitals, new entry drives them to do a better job. Thus, in addition to the harm to the consumers who would have chosen the new healthcare provider, CON laws harm society in general by depriving it of the increased efficiency that competition would have brought to the health care market.

3. CON Laws Impose Other Costs And May Facilitate Anti-Competitive Behavior

CON laws appear to raise a particularly substantial barrier to entry and expansion of competitors because they create an opportunity for existing competitors to exploit procedural

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[15] Report to the Congress: Physician-Owned Specialty Hospitals Revisited, pp. 21-25 (August 2006), available at http://www.medpac.gov/publications/congressional_reports/Aug06_specialtyhospital_mandated_report.pdf. ("MedPAC 2006 Report") (concluding that physician-owned specialty hospitals admit a lower proportion of Medicaid patients)

[16] Other studies have found that the presence of for-profit competitors leads to increased efficiency at nonprofit hospitals. Kessler, D. and McClellan M., "The Effects of Hospital Ownership on Medical Productivity," RAND Journal of Economics 33 (3), 488-506 (2002).

[17] Greenwald, L. et al., "Specialty Versus Community Hospitals: Referrals, Quality, and Community Benefits," *Health Affairs* 25, no. 1 (2006): 116-117. *See also* Stensland J. and Winter A., "Do Physician-Owned Cardiac Hospitals Increase Utilization?" *Health Affairs* 25, no. 1 (2006): 128 (some community hospitals have responded to the presence of specialty hospitals by recruiting physicians and adding new cardiac catheterization labs).

opportunities to thwart or delay new competition. Such behavior, commonly called "rent seeking" conduct, is a well-recognized consequence of regulatory intervention in the market.[18] Essentially, an existing competitor uses the hearing and appeals process to cause substantial delays, leading both the existing competitor and the new entrant to divert significant funds away from delivering healthcare and to spend them on legal fees, consulting fees, and lobbying efforts. Moreover, much of this conduct, even if exclusionary and anticompetitive, is unlikely to be subject to legal challenge as a violation of the antitrust laws because it involves petitioning of the state government by the existing competitor.[19] Indeed, during our hearings, we received evidence of the widespread recognition that existing competitors use the CON process "to forestall competitors from entering an incumbent's market."[20]

We have found that existing competitors, at times with the encouragement or acquiescence of state officials, go further and enter into agreements not required by the CON laws but nonetheless facilitated by them. Two examples arise from West Virginia, and a third comes from Vermont.

In the first West Virginia case, we found that a Charleston, West Virginia hospital used the threat of objection during the CON process, and the potential ensuing delay and cost, to induce a hospital seeking a certificate of need for an open heart surgery program not to apply for it at the location that would have well served Charleston consumers and provided greater competition for their business.[21] Instead, the Charleston hospital successfully prevented the possibility of this competing open heart program. The state authorities never had the opportunity to decide whether under the CON laws that second program would have been approved because of the unlawful agreement among the hospitals.

In the second West Virginia case, two closely competing hospitals decided to allocate healthcare services between themselves.[22] The informal urging of state CON officials led them to agree unlawfully that only the one hospital would apply for an open heart program and only the other would apply to provide cancer services. Again, the state took no official action and consumers were deprived of the potential competition between these hospitals.

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[18] Joskow, Paul and Rose, Nancy, "The Effects of Economic Regulation." *Handbook of Industrial Organization, vol. 2,* Schmalensee and Willig, ed. Amsterdam: North-Holland, 1989.

[19] *Eastern Rail. Pres. Conf. v. Noerr Motor Frgt., Inc.*, 365 U.S. 127 (1961).

[20] *A Dose of Competition*, Executive Summary at 22.

[21] *U.S. v. Charleston Area Medical Center, Inc.*, Civil Action 2:06 -0091 (S.D.W.Va. 2006) (available at: http://www.usdoj.gov/atr/cases/f214400/214477.htm).

[22] *U.S. v. Bluefield Regional Medical Center, Inc.*, 2005-2 Trade Cases ¶ 74,916 (S.D. W.Va. 2005).

A third example comes from the State of Vermont. There, home health agencies entered into territorial market allocations, again under cover of the state regulatory program, to give each other exclusive geographic markets.[23] That state's CON laws prevented competitive entry, which normally might have disciplined such cartel behavior. We found that Vermont consumers were paying higher prices than were consumers in states where home health agencies competed against each other.

We have learned from these matters and others that CON laws have the potential to impede competition in ways well beyond what is intended by their supporters.

III. Conclusion

My remarks are intended to convey to you our belief that CON laws impose substantial costs on consumers and healthcare markets. In light of these costs, the Antitrust Division believes that Alaska should carefully consider whether on balance its CON laws do more harm than good. Let me close by encouraging you not to accept without careful scrutiny claims that elimination of CON laws will visit significant harm on your state.

Thank you again for the opportunity to discuss our views on how CON laws affect competition and consumers in healthcare. I would be happy to take your questions.

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[23] Department of Justice Statement on the Closing of the Vermont Home Health Investigation, (Nov. 23, 2005) (available at: http://www.usdoj.gov/atr/public/press_releases/2005/213248.htm).

Alaska Health, Education & Social Services Committee

Testimony on Certificate of Need

by

Robert James Cimasi
MHA, ASA, CBA, AVA, CM&AA, CMP

January 29, 2008

Testimony Related to Alaska House Bill 337: ***An Act establishing the Alaska Health Care Commission and the Alaska Health Care Information Office; relating to healthcare planning and information; repealing the certificate of need program for certain healthcare facilities; and providing for an effective date"***

January 31, 2008

By Robert James Cimasi, MHA, ASA, CBA, AVA, CM&AA, CMP

Good afternoon Madam Chair and Members of the Alaska House of Representatives. Thank you for the opportunity to speak before the Alaska House Health Education & Social Services Committee regarding the proposed House Bill 337: "*An act establishing the Alaska Health Care Commission and the Alaska Health Care Information Office; relating to healthcare planning and information; repealing the Certificate of Need program for certain healthcare facilities; and providing for and effective date.*[1]"

My name is Robert James Cimasi. I am President of Health Capital Consultants, a national healthcare economic and financial consulting firm located in St. Louis, MO. On August 16, 2001, I was appointed to serve on the Acute Care Focus Group of the Missouri Certificate of Need Technical Advisory Committee (CONTAC) for the Missouri Health Facilities Review Committee (MHFRC). Over the past few years my firm has conducted dedicated, focused research resulting in a comprehensive reference manual & sourcebook encompassing the statutory, regulatory, administrative, and legal aspects of Certificate of Need (CON) regulation from its inception in the late 1960's to the present. Elements of this research on CON were published in December 2005, as *"The U.S. Healthcare Certificate Of Need Sourcebook"* which summarizes numerous studies, monographs, and research reports regarding CON regulations, as well as, law review, bar journal articles, and in excess of 700 published legal cases related to CON. Attached to your handouts is a brief description of my professional qualifications.

Over the years, the scope of my professional activities including testimony in court, before legislative, and agency hearings, has required and permitted me and my firm to conduct extensive research and analysis in the areas of healthcare delivery, public health planning, healthcare economics, and market competition; as well as, other Certificate of Need (CON) related topics. Based on these activities and experiences, it is my informed view that this committee should vote to advance House Bill 337 (hereinafter referred to as the PROPOSED BILLS).

CON is a failed public health policy which is bad for Alaska citizens and patients for several key reasons. The following topics should be addressed:

1. **CON's History as A Failed Health Planning Policy;**
2. **The Effects of CON Repeal in Several States;**
3. **The Federal Trade Commission's Repeated Denunciation of CON;**
4. **CON Has Failed to Lower Healthcare Costs;**
5. **CON is Anti-competitive;**

[1] Health Care Plan/Commission/Facilities by Alaska House of Representatives , Alaska House of Representatives, January 2008. http://www.legis.state.ak.us/basis/get_bill.asp?bill=HB%20337&session=25 (2008)

6. **CON is a Barrier to Healthcare Innovation;**
7. **CON Reduces Access and Patient Choice; and,**
8. **CON Hasn't Improved Healthcare Quality.**

1. CON's History as Failed Health Planning Policy

CON legislation was put in place nationally as a result of a Federal mandate in 1974. Based on over three (3) decades of experience, it is now clear that the CON process does not offer the better, more efficient solution to reducing healthcare cost that its proponents have proudly proclaimed. As Duke Professor of Law Clark Havighurst concludes "*Protectionist regulation, long discredited in other areas, is particularly misguided in healthcare, where health insurance greatly increases the profitability of monopoly and imposes the resulting higher costs on unwilling premium payers. To use cross-subsidies to finance even worthy (let alone unworthy) health care projects is to put public burdens unfairly (regressively) on the backs of working Americans.*"[2]

By 1986, the federal government had shifted its attitude toward CON regulation. Over a decade later, the federal CON legislation previously passed in 1974 had failed. The National Health Planning Act was repealed due to *"mounting empirical evidence that certificate of need cost containment objectives were not being realized."*[3]

Instead, the application of CON regulation has only encouraged erroneous outcomes, to the detriment of Alaska's public interest, on the basis of insufficient valid data, flawed methodology, arbitrary and capricious standards, and the ambiguity of unrestricted agency discretion in an atmosphere of political influence. The Alaskan CON process' almost total lack of applicable, valid empirical data; the absence of generally accepted methodological standards of economic and financial analysis, and the lack of consideration of all required pertinent variables, are based on statutes and rules that are so fatally flawed and so clearly based on arbitrary and capricious standards as to be unreasonably burdensome on the citizens and patients of Alaska. Your passage of House Bill 337 would relieve this onerous situation.

2. Effects of CON Repeal

The Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine published a study of the certificate-of-need program in the state of Washington on January 8, 1999. The results of this study are published as the "*Effects of Certificate of Need and Its Possible Repeal*". This meta-study, one of the most comprehensive efforts recently conducted in the area of CON, "*examined the effects of CON and its possible repeal on the cost, quality, and availability of five health services – hospitals, ambulatory surgery, kidney treatment, home health, and hospice – as*

[2] "Monopoly Is Not The Answer," By Clark C. Havighurst, Health Affairs, August 9, 2005.
[3] *See* Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act's Certificate of Need a Market Correction?*, 22 Me. B.J. 156 (2007).

well as on charity care and health services in rural areas."[4] Results of this study were based on literature review, interviews, and information from healthcare providers and healthcare economic experts in the State, as well as an analysis of eight (8) states which completely or partially repealed their CON laws (i.e. Arizona, Indiana, Ohio, Pennsylvania, Tennessee, Texas, Utah, and Wisconsin).[5] The study found that CON *"has not controlled overall healthcare spending or hospital costs."* It also found *"conflicting or limited evidence about the effects of CON on the quality and availability of other healthcare services or about the effects of repealing CON."*[6]

The study does not predict the effects of CON repeal; however, the study reflected that CON has been shown to restrict the supply of some specific health services in some areas, and inferred that, perhaps as a result, supply surges occurred in some specific health services of some areas.[7] Some supply surges were experienced in psychiatric hospitals and nursing homes (Utah); nursing homes and open heart surgery (Arizona); home health (Tennessee); hospitals, ambulatory surgery centers, dialysis, and pediatric services (Ohio); hospitals and psychiatric hospitals (Wisconsin) and nursing homes and psychiatric hospitals (Texas) after the repeal of CON.[8] These finding were not consistent in every state that completely or partially repealed their CON laws that was included in the Washington study.

> *"Not all states experience surges after repeal. When surges do occur, they tend to moderate over time"...In addition, initial surges are sometimes followed by periods of shakeout and stabilization. Therefore, while short term supply increases do appear at times after CON repeal, such surges have been insufficiently studied to determine if there are any persistent effects on cost (or on other goals such as quality and access).* [9]

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[4] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. i.
[5] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. ii, 6.
[6] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. iii.
[7] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. 10.
[8] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. 13.
[9] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, pp. 11, 13.

A 1998 empirical study, which examined health spending between the late 1970's and 1993 and looked at spending prior to and directly after state CON laws were repealed, stated:

> *"The major findings about CON can be summarized as follows: first, we found no surge in expenditures after CON was lifted; second, despite a statistically significant reduction by mature programs on acute spending per capita, there was no corresponding reduction in total per capita spending (apparently due to offsetting expenditures on non-hospital services)...We found that mature CON reduced hospital bed supply per capita population, but could detect no increase in bed supply following the removal of CON.*[10]

Further, the study authors found that established CON programs increased cost per adjusted patient day and also cost per admission.

According to a Conover and Sloan 1998 study, there was no empirical support that CON saved any money. Further, researchers concluded "There is no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations . . . CON regulations generally have no detectable effect on diffusion of various hospital-based technologies. It is doubtful that CON regulations have had much of an effect on quality of care, position of negative."[11] Experts have surmised that CON may increase the cost of health care. Administrative costs associated with state-level oversight and litigation expenses increase to the costs.[12] This is compounded by the problem that the CON approval process is highly technical in nature.

3. The Federal Trade Commission's Repeated Denunciation of CON;

3.1 FTC and DOJ Joint Hearings and Report on Healthcare Competition and CON

In November 2002, FTC Chairman, Timothy J. Muris, announced that the FTC would hold joint hearings with the DOJ on competition in healthcare in 2003.[13] On July 23, 2004, following the conclusion of the hearings lasting over six (6) months, the FTC and DOJ (agencies) issued a joint report on July 23, 2004, entitled "*Improving Health Care: A Dose of Competition*" in which the agencies recommended that states decrease barriers to entry into provider markets. The agencies encouraged states to reconsider whether CON programs "*best serve their citizens' health care*

[10] "Does Removing Certification-of-Need and Regulations Lead to a Surge in Health Care Spending?" Conover, Christopher J., Sloan, Frank A., Journal of Health Politics, Policy and Law, vol. 23, no. 3, June 1998, p. 455

[11] Christopher J. Conover, Frank A. Sloan, *Does Removing Certificate of Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL. POL'YY & L. 455 (1998).

[12] *See* Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act's Certificate of Need a Market Correction?*, 22 Me. B.J. 156 (2007).

[13] "FTC Chairman Announces Public Hearings on Health Care and Competition Law and Policy to Begin in February 2003" Federal Trade Commission, www.ftc.gov/opa/2002/11/murishealthcare.htm. (Accessed Aug. 5, 2004).

needs".[14]

Following testimony at numerous hearings from industry representatives and legal, economic, and academic experts on the healthcare industry and health policy, the agencies concluded that the burdens placed on competition by CON programs "*generally outweigh*" its "*purported economic benefits*". *The agencies suggested that instead of reducing costs, there is evidence that CON programs actually drive up costs by "fostering anticompetitive barriers to entry".*[15]

The agencies expressed concern that CON programs raise healthcare costs because they appear to be used to shield healthcare providers from competition. The agencies expressed further concern that CON programs tend to prevent entry into the market by enterprises that may be able to provide higher quality care, and the report contended that CON programs may delay the introduction of new technology. In support of their conclusions, the agencies relied upon empirical studies that showed CON programs generally failed to control costs and actually appear to result in higher healthcare costs.[16]

Subsequent to the FTC's July 23, 2004 report, on May 24, 2005 , the FTC delivered a statement before the SubCommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, the agency stated , " *vigorous competition can have important benefits in the hospital arena, just as in the multitude of markets in the U.S. economy that rely on competition to maximize the welfare of consumers. Competitive pressures can lead hospitals to lower costs, improve quality and compete more efficiently. Competitive pressures also may spur new types of competition. In hospital markets, some new entrants specialize and prove only a limited portion of the in-patient and out-patient services that general hospitals tend to provide*."[17] Specifically, the FTC testimony emphasized that, "*Overall, testimony at the FTC/DOJ Hearings identified a number of benefits that SSHs [single specialty hospitals] may offer to consumers, with no significant controversy about the potential for SSHs to provide those benefits. Rather, as discussed in more detail below, debate about SSHs generally centered on how they may affect the functioning of general hospitals.*"[18] Ultimately, the FTC testimony related to the efficacy of CON concluded that,

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[14] "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004, Executive Summary, p. 22.
[15] "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004, ch. 8, pp. 1-2.
[16] "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004, ch. 8, p. 4.
[17] Prepared Statement of the Federal Trade Commission Before the SubCommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, May 24, 2005, p. 3.
[18] Prepared Statement of the Federal Trade Commission Before the SubCommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, May 24, 2005, p. 8.

> *"The Commission believes that CON programs generally are not successful in containing health care costs, and that they can pose anticompetitive risk. As noted above, CON programs risk entrenching oligopolists and eroding consumer welfare. The aim of controlling costs is laudable, but there appear to be other, more effective means of achieving this goal that do not pose anticompetitive risks. Indeed, competition itself is often the most effective method of controlling costs. A similar analysis applies to the use of CON programs to enhance health care quality and access."*[19]

These Federal findings, by the FTC and DOJ, are only one of the significant pronouncements in the last several years that support the rational justification to eliminate CON and support a level playing field for providers in fostering *"a dose of"* market competition in healthcare.

3.2 Previous FTC Studies of CON

The FTC's unfavorable review of CON as a failed health policy planning mechanism is not a new event. Beginning in the late 1980s, the FTC issued several studies on CON and stated that, "*Market forces generally allocate society's resources far better than decisions of government planners.*"[20]

3.3 The FTC's Recommendations That States Repeal CON

The FTC has consistently recommended that the states remove their CON regulations. In a 1987 letter to Virginia officials they stated, *"Any potential benefits of CON regulation are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, CON regulation is likely to harm consumers on balance by increasing the price, and decreasing the quality, of health services in Virginia."*[21] The FTC has issued similar statements before numerous states considering the repeal of CON laws.

4. CON Has Failed To Lower Healthcare Costs

After nearly thirty (30) years of study, the preponderance of healthcare economic analysis has clearly indicated that CON laws have failed to achieve their stated objectives. In an article reviewing CON laws and their application to modern markets, Patrick J. McGinley, Esq. wrote, "*In searching the scholarly journals, one cannot find a single article that asserts that CON laws*

[19] Prepared Statement of the Federal Trade Commission Before the Subcommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, May 24, 2005, p. 18.
[20] Press Release from the Federal Trade Commission, Aug. 10, 1987
[21] Press Release from the Federal Trade Commission, Aug. 10, 1987

succeed in lowering healthcare costs."[22]

In fact, a 2003 study headed by David C. Grabowski entitled *"The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures"* found no significant increase in either nursing home or long-term care Medicaid expenditures in states that repealed their CON and moratorium laws.[23]

This confirmed the findings of an earlier 1998 study by Christopher J. Conover and Frank A. Sloan that mature CON laws resulted in a "*two percent (2%) reduction in bed supply but higher cost per-day and per admission, along with higher hospital profits.*"[24]

Additionally, a recent report commissioned by, and presented to the Georgia CON Commission by William S. Custer, Ph.D., entitled, "*Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program,*" dispels many of the continuing myths propounded by CON advocates which assert that CON controls healthcare costs. Dr. Custer described his findings related to the overall strategy of CON regulation as the management of the allocation of health care resources and prevention of the duplication of services by creating artificial barriers to market entry, resulting in monopoly of players already present in the market.[25] Further, in response to the Georgia Commission's request for Dr. Custer to study the efficacy of CON, Dr. Custer concluded that, contrary to the purpose of CON, basic economic theory suggests that monopolies generally have higher process and lower quality than firms in more competitive markets.[26]

Although one of the original purposes of CON was to restrict supply of hospital beds and services, the authors concluded that there does not seem to be a statistically significant correlation between a lower number of hospitals or hospital bed supply and the presence of CON regulation in the acute setting.[27] Of the states studied, while Georgia experienced the most rapid growth in the number of ambulatory surgery centers, it is important to highlight that the study

[22] "Beyond Health Care Reform: Reconsidering Certificate of Need Laws In a Managed Care Competition System", McGinley, PJ., Florida State University Law Review, 1995.
[23] "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures", Grabowski, David C., Ohsfeldt, Robert L., Morrisey, Michael A., Inquiry-Excellus Health Plan, vol. 40, no. 2, Summer 2003, p. 147.
[24] "Does Removing Certification-of-Need and Regulations Lead to a Surge in Health Care Spending?" Conover, Christopher J., Sloan, Frank A., Journal of Health Politics, Policy and Law, vol. 23, no. 3, June 1998, pp. 463, 466.
[25] "Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program," By William S. Custer, Ph.D. et al, October 2006, p.5.
[26] "Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program," By William S. Custer, Ph.D. et al, October 2006, p.5.
[27] "Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program," By William S. Custer, Ph.D. et al, October 2006, p.7.

found that there was "***not a statistically significant relationship between CON rigor and the number or growth of ASCs.***"[emphasis added].[28]

Recently, the proponents of CON have suggested that CON is necessary to protect charity care provided by community hospitals. However, this assertion has been strongly rebuked. Recently, a working paper prepared by the FTC concluded that, "*Most noticeable in all of the results is the lack of any statistically significant evidence for the cross-subsidization hypothesis. The data provides no statistically significant evidence that increased competition leads to reductions in charity care. The claim that hospitals will use market power to increase services to the poor is largely unsupported by this data.*"[29]

As stated by Clark C. Havighurst, a William Neal Reynolds Professor Emeritus of Law at Duke University School of Law, "*The huge enterprises that U.S. hospitals have become are largely unaccountable for the amounts of revenue they raise or the uses to which they put that money. Indeed, they are major contributors to ever-rising healthcare costs. Using CON regulation to maintain their ability to extract resources from the economy only to pour them back into more health care would keep costs under control. Competition is the best way both to limit dominant hospitals' claims on gross domestic product (GDP) and to restore voters and their representatives the power to decide just what extras are worth paying for.*"[30]

Aside from its ineffectiveness in reducing costs and its inability to promote charity care, CON itself incurs large administrative and indirect costs as an added burden on available healthcare funding. As Christopher J Conover, an assistant research professor with the Center for Health Policy, Law and Management in the Terry Sanford Institute of Public Policy at Duke University, recently stated, "*There is a significant amount of literature on the benefits and costs of regulation in the U.S. economy, with the first efforts to estimate the overall impact dating back to the mid-1970s. From this work it is known that regulations impose a considerable burden on U.S. businesses and consumers: the impact of regulation on the overall economy will approach $1 trillion in 2004.*" Specifically, Conover found that, CON regulations had a net cost of approximately $110 million, with no value to consumers. "*The most recent studies that use the most credible statistical methods and most recent data find no impact of CON regulation on health spending (and concomitantly no increase in health spending among states that have elected to drop CON regulation), so zero was used as the expected value.*"[31] The cost of attorneys, consultants, lobbyists and internal staff to healthcare organizations for CON

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[28] "Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program," By William S. Custer, Ph.D. et al, October 2006, p.8.
[29] "Hospital Competition and Charity Care," Working Paper No. 285By Christopher Garmon, Bureau of Economics Federal Trade Commission, October 2006, p.18.
[30] "Monopoly Is Not The Answer," By Clark C. Havighurst, Health Affairs, August 9, 2005.
[31] "Health Care Regulation A $169 Billion Hidden Tax," By Christopher J. Conover, Policy Analysis, No. 527, CATO Institute, October 4, 2004, pp.2, 8.

applications is considerable. Litigation and lobbying on both sides of the CON debate are other significant ccsts.

CON was originally conceived in the old payment structure plan of fee for service. With the advent of managed-care and the sea change it has brought to healthcare, CON is more useless now than ever. CON has devised what economist call the "Roemer Effect" which essentially means if there is a hospital bed to be filled, doctors will find a way to do so to increase their revenue. Yet managed care, with capitation payment schemes, has eliminated the "Roemer Effect" and the incentive to provide unnecessary or "duplicative" services. Physicians and hospitals are under pressure to constrain and control their expenses, not balloon them.[32]

5. CON is Anti-competitive

Competition creates choices for consumers and raises quality standards as providers compete for patient loyalty. A 1993 study found that hospitals in more competitive markets had average costs below those of less competitive markets.[33] According to Professor Carolyn Madden, "*[T]here is ... agreement across all perspectives of [health economics theory] on one issue: the negative consequences of too much concentration of economic power.*"[34]

The evidence presented by Ellen S. Campbell and Gary M. Fournier in their 1993 study entitled, *"Certificate-of-Need Deregulation and Indigent Hospital Care,"* commented on CON's anticompetitive effect, in suggesting that overall CON policy is absent of a *"clear, economic, and legal standard to distinguish between an action to deny an applicant in order to prevent investments that would raise costs by unnecessary duplication, and actions motivated by the anticompetitive effect of such denial...[T]he trouble is that agency decisions can often accomplish the latter while claiming the former."*[35]

As Duke Professor of Law Clark Havighurst concludes, *"But CON regulation was itself not clearly intended to suppress competition that is inconvenient for certain hospitals. Ostensibly, at least, the original rationale for enacting CON laws in the regulation-ridden 1970s was policymakers' belief that market forces could not be trusted to defer overinvestment in health facilities. Since that time, cost reimbursement have been replaced by prospective payment (even for capital expenditures), removing a major cause of the problem that first occasioned CON regulation. In addition, private health plans have developed the ability to steer patients to cooperative, low –cost providers, thereby signifying a "need" for the latter's facilities and*

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[32] *See* Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act's Certificate of Need a Market Correction?*, 22 Me. B.J. 156 (2007).

[33] "California Providers Adjust To Increasing Price Controls", Zwanziger J, Melnick G, Bamezai A., Health Policy Reform: Competition and Controls, AEI Press, 1993, pp. 241-58.

[34] Madden CW. "Excess capacity: markets, regulation, and values." Health Services Research. February, 1999.

[35] "Certificate-of-Need Deregulation and Indigent Hospital Care", Campbell, Ellen S., Fournier, Gary M., Journal of Health Politics, Policy and Law, vol. 18, no. 4, Winter 1993, pp. 922-923.

services and belying the old notion that supply can create its own demand. Thus, whatever, might have been the case in the earlier era, it is far from obvious today that CON regulation is needed to avoid excess capacity."[36]

Market competition in healthcare delivery provides economic empowerment to patients and payors by providing access; encouraging innovation and the investment of capital in overall cost saving technologies; and, by creating choices for consumers which, in turn, encourages providers to raise quality standards as they compete for patient loyalty. When patient choice is diminished, decisions about appropriate pricing/costs, access, quality, and beneficial outcomes become the sole purview of elite groups of oligopoly decision makers who, in the absence of healthy competition, are free to ignore market demands and patient needs. That circumstance is what drives the acceleration of costs.

6. CON is a Barrier to Healthcare Innovation

Because CON acts as a barrier to entry for new market entrant competitors, it slows the introduction of new healthcare facilities, equipment, and services and thus acts as a barrier to healthcare innovation. Famed economist Michael Porter wrote in the Harvard Business Review:

> *"In industry after industry, the underlying dynamic is the same: competition compels companies to deliver increasing value to customers. The fundamental driver of this continuous quality improvement and cost reduction is innovation. Without incentives to sustain innovation in healthcare, short-term cost savings will soon be overwhelmed by the desire to widen access, the growing health needs of an aging population, and the unwillingness of Americans to settle for anything less than the best treatments available. Inevitably, the failure to promote innovation will lead to lower quality or more rationing of care – two equally undesirable results."*[37]

CON repeal would remove unnecessary and irrational constraints and costly regulatory barriers to innovation; to investment in new technologies; to quality services; and, to cost-effective improvements, which, as the technology of healthcare advances, offer the true and valid opportunity to provide cost-effective quality healthcare to Alaska's citizens.

7. CON Reduces Access and Patient Choice

The fundamental and simplistic, yet flawed, idea of CON was straightforward: lower costs by "reducing duplication". However both competition and patient choice, by definition, require "duplication" of providers. Denial of patient choice in Alaska is tightly correlated with the barrier to entry posed by CON. New medical provider entrants, no matter how efficiently and

[36] "Monopoly Is Not The Answer," By Clark C. Havighurst, Health Affairs, August 9, 2005.
[37] "Making competition in health care work." By Michael Porter, et al. Harvard Business Review, July/Aug. 1994, p. 131.

creatively they might contribute to higher quality, more beneficial outcomes, and lower overall healthcare costs, face substantial opposition by these established oligopoly interests, who, historically, have actively strived to limit competition with the resulting impact of denying patient choice for Alaskans and their families.

Excess capacity is a value-laden term, not an absolute standard. In a February 1999 article published in Health Services Research, Professor Carolyn Madden summarized a number of studies of excess capacity saying, *"Without a clear statement of this standard [e.g., the correct number of hospital beds], we cannot determine what constitutes too many. The research literature provides no clear statement."*[38]

Access issues are especially important in rural areas where patients must travel long distances and have little choice of provider. Access is closely linked to patient choice. When choice is diminished, decisions about access, quality, and beneficial outcomes are made in isolation by healthcare businesses. In the absence of healthy competition, they are free to ignore patient needs and demands.

Under CON laws, patients are *de facto* limited to accept the services that existing providers wish to offer them when making major healthcare decisions for themselves and their families because their geographic region may be determined by CON administrators to lack a sufficient utilization ratio to allow alternative market entrants.

8. CON Hasn't Improved Healthcare Quality

CON proponents, faced with irrefutable empirical data and evidence that CON has utterly failed, now have attempted to shift their ever-changing arguments to a new focus, that CON protects quality. They claim that by limiting the number of locations for highly technical surgeries and procedures, that each location and surgeon gains a greater level of experience with these procedures, which results in better quality outcomes. Part of this argument by CON proponents is based on the disingenuous quoting of research from *"The Dartmouth Atlas of Healthcare"* which does not support this assertion. Further, there have been a number of studies which contradict these assertions.[39] An article, in the March 2003 issue of Health Affairs entitled, *"Why Competition Law Matters To Health Care Quality"* once again refutes the validity of these CON proponents latest desperate move to maintain this failed policy.[40]

Healthcare economists know that in the absence of sustained competition, large provider systems have little or no incentive to offer the highest quality at the lowest price. Effective health policy

[38] Madden CW. "Excess capacity: markets, regulation, and values." Health Services Research. February, 1999.
[39] "Is volume related to outcome in health care? A Systematic review and methodologic critique of the literature", Annals of Internal Medicine, Sept. 17, 2002, p. 511.
[40] "Why competition law matters to health care quality", Health Affairs, Vol. 22, no. 2 (March/April 2003), p. 31.

planning should let the quality of services and beneficial outcomes define the level of competition, not the present failed system of CON review.

CON essentially serves as an ineffective means for rationing healthcare access to facilities, equipment (often innovation and technology) and services, thereby acting to ration care. Expanded access to healthcare and innovative new technologies has transformed modern lifestyles, improved the quality of life and life expectancy in the U.S., and contributed to increased productivity in the U.S. workforce. A CON regulatory system that has demonstrated that it cannot control costs, even by irrationally rationing healthcare, has now, in desperation, turned to the "Quality and Safety" issues as the "refuge of a scoundrel."

9. Summary

CON, although began with the best intentions, has failed in its goals of reducing costs, improving access and quality of care, and preventing duplication of medical services.[41]

In my view, the Alaska House of Representatives Health Education and Social Services Committee has an opportunity on behalf of the citizens of the State of Alaska to thoroughly investigate and eliminate a clearly failed health planning policy, which has undoubtedly cost the taxpayers of Alaska more than had CON never existed and impeded healthcare access for Alaska patients and their families. The Federal government, who first imposed CON on all the states, learned this early on after the change from a "cost plus" to a "prospective payment system" and has repeatedly denounced this failed health planning policy. CON has not achieved its stated purpose of reducing overall healthcare costs, as demonstrated by the preponderance of empirical evidence. Further, CON has caused severe regulatory interference in the healthcare market economy of Alaska in an uninformed, irrational, unfair and capricious manner.

I close by making a request of this committee and a commitment. The request is to urgently ask you to advance the efforts to repeal CON in Alaska. I commit to you that I will make available to you whatever related performance data, information and research related to the history of CON and its implementation in the State of Alaska as you may request. I urge you to get informed on this issue and offer to make myself and my staff available to any of you that may wish additional information in support of my position. I remain confident that once you have the facts, CON regulation in Alaska will be repealed.

Respectfully Submitted,

[41] *See* Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act's Certificate of Need a Market Correction?*, 22 Me. B.J. 156 (2007).

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Providing Solutions in the Era of Healthcare Reform

EXPERIENCE

Robert James Cimasi, MHA, ASA, CBA, AVA, CM&AA, CMP is President of **HEALTH CAPITAL CONSULTANTS** (HCC), a nationally recognized healthcare financial and economic consulting firm. With over twenty years (20) of experience in serving clients, in over forty five (45) states, his professional focus is on the financial and economic aspects of healthcare service sector entities including: valuation consulting; litigation support & expert testimony; business intermediary and capital formation services; certificate-of-need and other regulatory and policy planning consulting; and, healthcare industry transactions including joint ventures, sales, mergers, acquisitions, and divestitures.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, the Accredited Senior Appraiser (ASA) designation in Business Valuation, as well as, the Certified Business Appraiser (CBA), Accredited Valuation Analyst (AVA), the Certified Merger & Acquisition Advisors (CM&AA), and the Certified Medical Planner (CMP) professional designations (see *Professional Designations* section below). He is a nationally known speaker on healthcare industry topics, who has served as conference faculty or presenter for such organizations as the American Society of Appraisers (ASA), the Institute of Business Appraisers (IBA), the American Institute of Certified Public Accountants (AICPA), the National Association of Certified Valuation Analysts (NACVA), the American College of Healthcare Executives (ACHE), the National Society of Certified Healthcare Business Consultants(NSCHBC), the Academy Health, Healthcare Financial Management Association (HFMA), the American Association of Ambulatory Surgery Centers (AAASC),Physician Hospitals of America (PHA) f/k/a American Surgical Hospital Association (ASHA), National Litigation Support Services Association (NLSSA), as well as many other national and state healthcare industry associations and professional societies, trade groups, companies and organizations. He has been certified and has served as an expert witness on cases in numerous states, and has provided testimony before federal and state legislative committees. In 2006, Mr. Cimasi was honored with the prestigious *Shannon Pratt Award in Business Valuation* conferred by the Institute of Business Appraisers and was recently elevated to its College of Fellows in 2007. Mr. Cimasi is the author of *A Guide To Consulting Services for Emerging Healthcare Organizations* (John Wiley & Sons, 1999), *The Valuation of Healthcare Entities in a Changing Regulatory and Reimbursement Environment* (IBA Course 1011 text - 1999), and the author of *An Exciting Insight Into the Health Care Industry and Medical Practice Valuation* (AICPA course text 1997, rev. 2006.) He has authored chapters on healthcare valuation in The Handbook of Business Valuation (John Wiley & Sons), *Valuing Professional Practices and Licenses: A Guide for the Matrimonial Practitioner, 3rd ed., 1999* (Aspen Law & Business), and *Valuing Specific Assets in Divorce* (Aspen Law & Business) and has been a contributor to The Guide to Business Valuations (Practitioners Publishing Company), *Physician's Managed Care Success Manual: Strategic Options, Alliances, and Contracting Issues* (Mosby), and numerous other chapters. He has written published articles in peer review journals, frequently presented research papers and case studies before national conferences, and is often quoted by healthcare industry professional publications and the general media. Mr. Cimasi's latest book, *The U.S. Healthcare Certificate of Need Sourcebook*, was published in 2005 by Beard Books.

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U.S. Department of Justice

Antitrust Division

Competition in Healthcare and Certificates of Need

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U.S. Department of Justice, Antitrust Division

January 31, 2008[1]

Good afternoon. I appreciate the invitation to the Antitrust Division of the U.S. Department of Justice to share our views on the impact of Certificate of Need ("CON") laws on healthcare markets.

My name is Joseph Miller. I am the Assistant Chief of the Litigation I Section of the Antitrust Division. The Litigation I Section enforces the antitrust laws in a wide variety of industries, including healthcare markets. Our attorneys confer closely with a large team of economists holding doctorates in the study of markets and their performance, including a number with specialization in the performance of healthcare markets. We also confer closely with the attorneys and economists at the Federal Trade Commission, who have dedicated time to the study of healthcare markets.

The Antitrust Division and the FTC have investigated and litigated antitrust cases in markets across the country involving hospitals, physicians, ambulatory surgery centers, stand-alone radiology programs, medical equipment, pharmaceuticals and other healthcare products. Through that work we have developed a substantial understanding of the competitive forces that drive innovation in and contain the costs of healthcare. We regularly issue informal advisory letters on the application of the antitrust laws to healthcare markets, and periodically issue reports and general guidance to the healthcare community. For example, in 2003, we conducted 27 days of hearings on competition and policy concerns in the healthcare industry, heard from approximately 250 panelists, elicited 62 written submissions, and generated almost 6,000 pages of transcripts.[2] As a result of that effort, we published an extensive report, entitled *Improving Health Care: A Dose of Competition*, in July 2004.

I. Scope of Remarks

The Antitrust Division's experience and expertise has taught us that Certificate of Need laws pose a substantial threat to the efficient performance of healthcare markets. By their very nature, CON laws create barriers to entry and expansion and thus restrict free and open

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[1] This paper draws significantly from testimony delivered on behalf of the Antitrust Division to the General Assembly and Senate of the State of Georgia on February 23, 2007.

[2] This extensive hearing record is largely available at http://www.ftc.gov/bc/healthcare/research/healthcarehearing.htm.

competition. They undercut consumer choice, weaken markets' ability to contain healthcare costs, and stifle innovation.

We have examined historical and current arguments for CON laws, and conclude that such arguments provide no economic justification for depriving consumers' of the benefits of free markets. To the extent that CONs are used to further non-economic goals, they impose substantial costs. Such goals, purportedly furthered through CON laws, can be more efficiently achieved through other mechanisms. We hope you will carefully consider the substantial costs that CON laws impose on consumers as you evaluate whether to eliminate those laws in Alaska.

I do not testify today to discuss the details of the legislation you are considering. I am, however, generally familiar with the issues before you and recognize them as issues that CON laws present in other states and other markets. My remarks, accordingly, will focus on the impact of and justifications for CON laws generally.

It is not the Antitrust Division's intent to "favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, [our] goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices . . ."[3] Our overall mission is to preserve and promote economic competition rather than to preserve any particular marketplace rival or group of rivals.

II. Importance of Competition and the Harm Caused by Regulatory Barriers to Entry

A. The Benefits of Competition in Healthcare

Our concerns about the harm from CON laws are informed by one fundamental principle: market forces improve the quality and lower the costs of healthcare services. They drive innovation and ultimately lead to the delivery of better healthcare. Government intervention can undermine market forces to the detriment of healthcare consumers.

In our antitrust investigations we often hear the argument that healthcare is "different" and therefore competition principles do not apply to the provision of healthcare services. The proposition that competition cannot work in healthcare is simply not true. Engineers and lawyers have made similar arguments that competition does not work in their industries and, in fact undermined other social goods advanced by their professions. Such arguments have been rejected by the courts, and private restraints on competition have long been condemned.[4] Indeed, at least since the Supreme Court's seminal 1943 decision in a case brought by the Department of Justice against the American Medical Association, competition has played a critical role in

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[3] Statements of Antitrust Enforcement Policy in Health Care, August 1996, Introduction, pg. 3 (available at: http://www.usdoj.gov/atr/public/guidelines/1791.htm).

[4] *F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990); *National Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978).

shaping the delivery of healthcare in this country.[5] The Antitrust Division and the Federal Trade Commission have worked diligently to make sure that private barriers to that competition do not arise.

During our extensive healthcare hearings in 2003, we obtained substantial evidence generally about the role of competition in our healthcare delivery system and reached the conclusion that vigorous competition among healthcare providers "promotes the delivery of high-quality, cost-effective healthcare." Specifically, competition results in lower prices and broader access to health care and health insurance, while non-price competition can promote higher quality.[6]

This finding is not new. We saw in the 1990s the growth of managed care and the impact it had on the cost and availability of insurance. Competition among and between hospitals and physicians intensified with the development of managed care organizations. In addition to putting pressure on costs, managed care plans have pressured providers to use shorter hospital stays and to offer alternative outpatient treatments. This evolution in health care purchasing led to lower costs and increased choice without sacrificing quality. Moreover, lower costs and improved efficiency made health insurance more affordable and available.

Competition also helped bring to consumers important innovations in healthcare technology. For example, health plan demand for lower costs and "patient demand for a non-institutional, friendly, convenient setting for their surgical care" drove the growth of Ambulatory Surgery Centers (ASCs). [7] Ambulatory surgery centers offered patients more "convenient locations, shorter wait time, and lower coinsurance than a hospital department."[8] Important to the success of these competitive forces in improving the delivery of care to consumers was the availability of technological advances, such as endoscopic surgery and advanced anesthetic agents.[9] Thus, competition harnessed this new technology and brought it to consumers in the lower cost, more convenient setting of ambulatory surgery centers. The impact on traditional general acute care hospitals led to those hospitals responding to the competition by delivering more care, in a better manner, in an outpatient setting, both at their own campuses and at ambulatory surgery centers in which they invested.

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[5] *American Medical Association v. U.S.*, 317 U.S. 519, 529 (1943).

[6] *Improving Health Care: A Dose of Competition*, ch. 3 § VIII and Executive Summary at 4 (July 2004) available at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf. ("*A Dose of Competition*").

[7] Id., Ch. 3 at 25.

[8] Medicare Payment Advisory Commitions (MedPAC), Report to the Congress: Medicare Payment Policy § 2F, at 140 (2003), available at http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf.

[9] A Dose of Competition, at ch. 3 at 24.

This type of competitive success story has occurred again and again in healthcare in the area of pharmaceuticals, urgent care centers, and elective surgeries such as Lasik procedures, to name just a few. Without private or governmental impediments to their performance, we can expect healthcare markets to continue to deliver these benefits.

B. CON Laws Create Barriers to Beneficial Competition

CON laws are a classic government-erected barrier to entry, and by their nature are an impediment to the proper functioning of the market process. Accordingly, in *A Dose of Competition*, the Federal Trade Commission and we urged the states to rethink their CON laws.[10]

1. Original Cost-Control Reasons For CON Laws No Longer Apply

We made that recommendation in part because the original reason for the adoption of CON laws is no longer valid. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974, which offered incentives for states to implement CON programs. At the time, the federal government and private insurance reimbursed healthcare charges predominantly on a "cost-plus" basis, which provided incentives for over-investment. The hope was that CON laws would provide a counterweight against that skewed incentive.

In considering this historical justification for CON laws, we need to keep clear that a number of other arguments made today in support of CON laws were not part of the rationale for their original adoption –

* CON laws were not adopted as a means of cross-subsidizing care;
* CON laws were not adopted in order to have centralized planning of the location and nature of healthcare facilities; and,
* CON laws were not adopted to protect the health and safety of the population from poor quality medicine.

Instead, CON laws were adopted because excessive capital investments, spurred by the then-current cost-plus method of reimbursement, were driving up healthcare costs. There was concern that, because patients are usually not price-sensitive, providers engaged in a "medical arms race" by unnecessarily expanding their services to offer the perceived highest quality services.[11]

CON laws appear to have failed in their intended purpose of containing costs. Several studies have examined the effectiveness of CONs in controlling costs. The empirical evidence

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[10] *A Dose of Competition*, Executive Summary at 22.

[11] *A Dose of Competition*, Ch. 8, pg. 1-2.

on the economic effects of CON programs has demonstrated near-universal agreement among health economists that CON laws were unsuccessful in containing healthcare costs.[12]

In addition to the fact that CON laws have been ineffective in serving their original purpose, CON laws should be reexamined because the reimbursement methodologies that may in theory have justified them initially have changed significantly since the 1970s. The federal government no longer reimburses on a cost-plus basis. In 1986, Congress repealed the National Health Planning and Resources Development Act of 1974. Additionally, health plans and other purchasers routinely bargain with healthcare providers over prices. Essentially, government regulations have changed in a way that eliminates the original justification for CON programs.[13]

2. Protecting Revenues of Incumbents Does Not Justify CON Laws

Incumbent hospitals often argue that they should be protected against additional competition so that they can continue to cross-subsidize care provided to uninsured or under-insured patients. Under this rationale, CON laws would impede the entry of such healthcare providers as independent ambulatory surgery centers, free-standing radiology or radiation-therapy providers, single- or multi-specialty physician-owned hospitals, because if these new competitors were to enter the marketplace, community hospitals could not continue to exploit their existing market power over consumers. Put another way, without CON laws, we would see new, higher-quality, low cost providers in the marketplace, which would put competitive pressure on incumbent providers, and deprive them of revenues they could put to a charitable use.[14]

We fully appreciate the laudatory goal of providing sufficient funding for community hospitals so that these hospitals can provide healthcare services to those who cannot afford them and for whom government payments are either unavailable or too little to cover the cost of care. But, we also want to make clear that the use of government barriers to entry to fund indigent care has costs. There are more efficient ways to accomplish this goal without incurring the costs of impeding the proper functioning of health care markets. Essentially, by protecting incumbent hospitals from competition, CON laws allow dominant hospitals to tax consumers through the exercise of market power in order to pursue the charitable goal of providing care to other, less fortunate consumers. In using that funding mechanism, however, the CON laws may do more harm than good.

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[12] David S. Salkever, Regulation of Prices and Investment in Hospital in the United States, in 1B Handbook of Health Economics, 1489-90 (A.J. Culyer & J.P. Newhouse eds., 2000) ("there is little evidence that [1970's era] investment controls reduced the rate of cost growth.")

[13] *A Dose of Competition* at pg. 1-6.

[14] Note the irony of this argument: What started as laws intended to control costs have become laws intended to inflate costs. Proponents of CON laws now would use these barriers to entry to stifle competition, protect incumbent market power, frustrate consumer choice, and keep prices and profits high.

First, CON laws harm the consumers who would have chosen alternative, lower priced, higher quality, or more convenient sources of care.

Second, CON laws impose that cost without any clear evidence that other desired social goals are advanced. The evidence to date indicates that new competition does not undercut community hospitals' ability to fulfill charitable missions. Rec ntly the federal government studied just this issue in connection with the emergence of single-specialty hospitals around the country. The study found that, for several reasons, specialty hospitals did not undercut the financial viability of rival community hospitals.[15] One substantial reason for this was that specialty hospitals generally locate in areas that have above average population growth. Thus, they are competing for a new and growing patient population, not just siphoning off the existing customer base of the community hospitals.

Third, new competition can force community hospitals to improve their performance. In studying the effect of single-specialty hospitals, MedPAC found that the community hospitals responded to the competition by improving efficiency, adjusting their pricing, and expanding profitable lines of business.[16] Community hospitals encouraged physicians to perform procedures on the hospital campus by developing centers of excellence and building physician offices on campus.[17] Overall, community hospitals affected by specialty hospital entry maintained profit margins in line with national averages. Rather than undercutting community hospitals, new entry drives them to do a better job. Thus, in addition to the harm to the consumers who would have chosen the new healthcare provider, CON laws harm society in general by depriving it of the increased efficiency that competition would have brought to the health care market.

3. CON Laws Impose Other Costs And May Facilitate Anti-Competitive Behavior

CON laws appear to raise a particularly substantial barrier to entry and expansion of competitors because they create an opportunity for existing competitors to exploit procedural

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[15] Report to the Congress: Physician-Owned Specialty Hospitals Revisited, pg. 21-25 (August 2006), available at http://www.medpac.gov/publications/congressional_reports/ Aug06_specialtyhospital_mandated_report.pdf. ("MedPAC 2006 Report") (concluding that physician-owned specialty hospitals admit a lower proportion of Medicaid patients)

[16] Other studies have found that the presence of for-profit competitors leads to increased efficiency at nonprofit hospitals. Kessler, D. and McClellan M., "The Effects of Hospital Ownership on Medical Productivity," RAND Journal of Economics 33 (3), 488-506 (2002).

[17] Greenwald, L. et al., "Specialty Versus Community Hospitals: Referrals, Quality, and Community Benefits," *Health Affairs* 25, no. 1 (2006): 116-117. *See also* Stensland J. and Winter A., "Do Physician-Owned Cardiac Hospitals Increase Utilization?" *Health Affairs* 25, no. 1 (2006): 128 (some community hospitals have responded to the presence of specialty hospitals by recruiting physicians and adding new cardiac catheterization labs).

opportunities to thwart or delay new competition. Such behavior, commonly called "rent seeking" conduct, is a well-recognized consequence of regulatory intervention in the market.[18] Essentially, an existing competitor uses the hearing and appeals process to cause substantial delays, leading both the existing competitor and the new entrant to divert significant funds away from delivering healthcare and to spend them on legal fees, consulting fees, and lobbying efforts. Moreover, much of this conduct, even if exclusionary and anticompetitive, is unlikely to be subject to legal challenge as a violation of the antitrust laws because it involves petitioning of the state government by the existing competitor.[19] Indeed, during our hearings, we received evidence of the widespread recognition that existing competitors use the CON process "to forestall competitors from entering an incumbent's market."[20]

We have found that existing competitors, at times with the encouragement or acquiescence of state officials, go further and enter into agreements not required by the CON laws but nonetheless facilitated by them. Two examples arise from West Virginia, and a third comes from Vermont.

In the first West Virginia case, we found that a Charleston, West Virginia hospital used the threat of objection during the CON process, and the potential ensuing delay and cost, to induce a hospital seeking a certificate of need for an open heart surgery program not to apply for it at the location that would have well served Charleston consumers and provided greater competition for their business.[21] Instead, the Charleston hospital successfully prevented the possibility of this competing open heart program. The state authorities never had the opportunity to decide whether under the CON laws that second program would have been approved because of the unlawful agreement among the hospitals.

In the second West Virginia case, two closely competing hospitals decided to allocate healthcare services between themselves.[22] The informal urging of state CON officials led them to agree unlawfully that only the one hospital would apply for an open heart program and only the other would apply to provide cancer services. Again, the state took no official action and consumers were deprived of the potential competition between these hospitals.

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[18] Joskow, Paul and Rose, Nancy, "The Effects of Economic Regulation." *Handbook of Industrial Organization, vol. 2*, Schmalensee and Willig, ed. Amsterdam: North-Holland, 1989.

[19] *Eastern Rail. Pres. Conf. v. Noerr Motor Frgt., Inc.*, 365 U.S. 127 (1961).

[20] *A Dose of Competition*, Executive Summary at 22.

[21] *U.S. v. Charleston Area Medical Center, Inc.*, Civil Action 2:06 -0091 (S.D.W.Va. 2006) (available at: http://www.usdoj.gov/atr/cases/f214400/214477.htm).

[22] *U.S. v. Bluefield Regional Medical Center, Inc.*, 2005-2 Trade Cases ¶ 74,916 (S.D. W.Va. 2005).

A third example comes from the State of Vermont. There, home health agencies entered into territorial market allocations, again under cover of the state regulatory program, to give each other exclusive geographic markets.[23] That state's CON laws prevented competitive entry, which normally might have disciplined such cartel behavior. We found that Vermont consumers were paying higher prices than were consumers in states where home health agencies competed against each other.

We have learned from these matters and others that CON laws have the potential to impede competition in ways well beyond what is intended by their supporters.

III. Conclusion

My remarks are intended to convey to you our belief that CON laws impose substantial costs on consumers and healthcare markets. In light of these costs, the Antitrust Division believes that Alaska should carefully consider whether on balance its CON laws do more harm than good. Let me close by encouraging you not to accept without careful scrutiny claims that elimination of CON laws will visit significant harm on your state.

Thank you again for the opportunity to discuss our views on how CON laws affect competition and consumers in healthcare. I would be happy to take your questions.

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[23] Department of Justice Statement on the Closing of the Vermont Home Health Investigation, (Nov. 23, 2005) (available at: http://www.usdoj.gov/atr/public/press_releases/2005/213248.htm).

I. Introduction

KMD Services & Consulting was contracted by the State of Alaska, Department of Health and Human Services (DHSS) to facilitate the Certificate of Need Negotiated Rulemaking Committee. Kevin Dee was lead facilitator. This was the first ever attempt to bring various vested parties together to attempt to reach consensus on the "Certificate of Need" (CON) process, rules and regulations.

The Committee members were selected through a voluntary process by DHSS and five days of meetings to review and make recommendations were held. The committee was asked to look at anything and everything related to the CON process including statutes, regulations and processes. The dates of the meetings were; October 29-30, 2007, November 13-14, 2007 & November 20, 2007. There were between 19 – 21 committee members present at all meetings. Committee members were comprised of Doctors and Hospital administrators and one representative from DHSS . The actual participants of the committee varied from session to session due to substitutions. The committee members and their attendance are listed below.

Certificate of Need Negotiated Regulation Committee Members

Present at meeting = X , Absent = A, Substitute = Sub

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1	Imaging	[illegible] Health of Anchorage	X	X	X	Sub	X	
2	Imaging	Jeff Kinion, CEO Alaska Open Imaging Center Wasilla	X	X	X	X	X	
3	Imaging	[illegible] Bridges, MD [illegible] Diagnostic Imaging, LLC [illegible]	X	X	X	X in am only, pm = Sub	X	Kim Black sub in afternoon
4	Imaging	Chakri Inampudi, MD Alaska Radiology Associates Anchorage	X	X	X*	X	X	*Left prior to meeting end on 11/13
5	Imaging	Bradley K. Cruz, M.D. Alaska Imaging Associates, LLC Anchorage	X	X	X	X	Sub	Lester Lewis, MD

I. Introduction

KMD Services & Consulting was contracted by the State of Alaska, Department of Health and Human Services (DHSS) to facilitate the Certificate of Need Negotiated Rulemaking Committee. Kevin Dee was lead facilitator. This was the first ever attempt to bring various vested parties together to attempt to reach consensus on the "Certificate of Need" (CON) process, rules and regulations.

The Committee members were selected through a voluntary process by DHSS and five days of meetings to review and make recommendations were held. The committee was asked to look at anything and everything related to the CON process including statutes, regulations and processes. The dates of the meetings were; October 29-30, 2007, November 13-14, 2007 & November 20, 2007. There were between 19 – 21 committee members present at all meetings. Committee members were comprised of Doctors and Hospital administrators and one representative from DHSS . The actual participants of the committee varied from session to session due to substitutions. The committee members and their attendance are listed below.

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	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1	Imaging	Ward Hinger, Administrator Diagnostic Health of Anchorage	X	X	X	Sub	X	Aaron Woolrich
2	Imaging	Jeff Kinion, CEO Alaska Open Imaging Center Wasilla	X	X	X	X	X	
3	Imaging	Robert Bridges, MD Aurora Diagnostic Imaging, LLC, Fairbanks	X	X	X	X in am only pm = Sub	X	Kim Black sub in afternoon
4	Imaging	Chakri Inampudi, MD Alaska Radiology Associates Anchorage	X	X	X*	X	X	*Left prior to meeting end on 11/13
5	Imaging	Bradley K. Cruz, M.D. Alaska Imaging Associates, LLC, Anchorage	X	X	X	X	Sub	Lester Lewis, MD

	Represents	Name	10/29	10/30	11/13	11/14	11/20	Substitute
6	Hospital	Shawn Morrow, CEO Bartlett Regional Hospital Juneau	X	X	X	X	X	
7	Hospital	James Shill, CEO Northstar Behavioral Health Systems, Anchorage	X	X	X	A	X	
8	Hospital	Edward Lamb, CEO Alaska Regional Hospital Anchorage	Sub	Sub	A	[illegible]	Sub	Jordan Herget = 10/29 & 10/30 Paul Morris = 11/20
9	Hospital	E. Al Parrish, CEO/VP Providence Health System Anchorage	X in am only pm = Sub	X in am only pm = Sub	Sub	Sub	Sub	Joel Gilbertson 4/5 of sessions
10	Hospital	Mike Powers, CEO/Administrator Fairbanks Memorial Hosp./Denali Center Fairbanks	X	X	X	X	X	
11	Hospital	Norman Stephens, CEO Mat-Su Regional Medical Center, Palmer	X	X	Sub	Sub	X	Michael Zielaskiewkz
12	Hospital	Ryan K. Smith, CEO Central Peninsula Hospital Soldotna	X	X	Sub	Sub	X	Jason Paret
13	Physician group	Creed Mamikunian, M.D. Anchorage	X	X	X	X (am only)	Sub	Vicki Crumptoula
14	Physician group	Baxter Burton, CEO Alaska Heart Institute, LLC Anchorage	X	X	X	A	X	
15	Physician group	Gerald L. Nicholson, Administrator Katmai Oncology Group, LLC Anchorage	A	A	A	X	A	
16	Physician group	Jeremy Hayes Advanced Medical Centers of Alaska Anchorage	X	X	X	Sub in am / X pm	X	Cathy Giessel
17	Physician group	Bruce Jayne Alaska Surgery Center	X	X	X	X	Sub	William Pethick

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17	Physician group	Bruce Jayne Alaska Surgery Center	X	X	X	X	Sub	William Pethick

18	Association (physician)	J. Ross Tanner, ASMA President	Sub	Sub	A	A	Sub	ASMA E.D. James Jordan served as designated substitute
19	Tanana Chiefs	Victor Joseph, Health Director Tanana Chiefs Conference Health Svcs, Fairbanks	X	X	X	X*	X	*Left prior to meeting end [illegible]
20	DHSS	Jay Butler, MD, FAAP, FACP Chief Medical Officer, DHSS Anchorage	X	X	X	X	X	
21	Association (hospital and nursing home)	Rod Betit, CEO Alaska State Hospital & Nursing Home Association	X	X	X	A	X	
22	Physician group	Mark Wade, MD. Fairbanks	NA	NA	X	X	A	Late entry to committee, Resigned after 11/14 meeting

II. Committee Negotiation Processes

A set of ground rules for discussion was implemented throughout the committee meetings;

ESTABLISHED GROUND RULES:

- Seek first to understand then to be understood
- Speak directly to your point
- Respect everyone's choices as right for them
- Spend 10% of your time identifying concerns & issues, 90% of your time identifying options & solutions
- Focus on choices and consequences versus right and wrong
- All Voices count
- Follow facilitator instructions

The committee used open group discussion to determine topics and points of view on each subject and questions for voting were developed. Voting was conducted using an electronic anonymous (Consensor) polling system to determine the level of consensus of the group on specific topics.

Representing	Name	10/25	10/30	[illegible]	11/14	11/20	[illegible]
18 Association (physician)	J. Ross Tanner, ASMA President	Sub	Sub	A	A	Sub	ASMA E.D. James Jordan served as designated substitute
19 Tanana Chiefs	Victor Joseph, Health Director Tanana Chiefs Conference Health Svcs., Fairbanks	X	X	X	X*	X	*Left prior to meeting end
20 DHSS	Jay Butler, MD, FAAP, FACP Chief Medical Officer, DHSS Anchorage	X	X	X	X	X	
21 Association (hospital and nursing home)	Rod Betit, CEO Alaska State Hospital & Nursing Home Association	X	X	X	A	X	
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Testimony on HB 337
Jeannine C. Hinman, JD

Director, Regulatory & Government Affairs
Advanced Medical Centers of Alaska

Madame Chairwoman, Members of the Committee, I am here today representing my company in support of the Governor's Bill and particularly in support of repealing the Certificate of Need Program here in Alaska.

There are 4 general reasons we support the Governor's Bill and we have provided data for each of these reasons. We believe the data demonstrates that:

1) Repealing the CON will increase the quality of medical care here,
2) Repealing the CON will improve access to care; and
3) Lead to more physicians coming to this state.
4) Repealing the CON will actually lower, not raise, the costs of care for the consumer and the state.

We hope the committee will carefully assess our data and the sources of it. There are a lot of claims being made by the out of state corporations who wish to retain the CON program as it is today. I urge you to question their claims, and assess the relevance and objectivity of their sources, and look at who benefits the most from CON because it is not the Alaskan consumer or patient.

Originally the CON program was designed to reduce redundancies and increase efficiencies of resources for health care as a way to keep costs down and help the patients. It has failed. The Governor's bill is NOT about attacking locally owned hospitals. On the contrary, the large hospitals here are owned by out of state corporations who are trying to prevent local doctors from opening any type of business that they feel encroaches on their market share.

The scare tactics the hospitals use include the idea that they'll all go bankrupt if anyone dares to provide health care other than them. Repealing the CON will not lead to The financial disaster they claim. In fact, both Providence and Fairbanks Memorial are ~~owned or~~ operated by out of state corporations who are flourishing and within those corporate health care systems the hospitals INSIDE Alaska, are reportedly their most profitable.

We urge you to read their financial statements and reports carefully scrutinizing their medical loss ratios, which translates to profit margin. For instance, in 2005, FMH reported in their CON application, of January of 2007, that their revenue/costs per day ratio is 1.38. This translates to a 38% profit margin. Not bad.

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FEB 19 2008

AHIP Board of Directors Statement on Promoting a Value-Based Health Care System through Transparency

Approved by AHIP Board of Directors on November 9, 2006

Over the last decade, studies by the Institute of Medicine (IOM), RAND, Dartmouth and others have revealed alarming problems in the U.S. health care system, including wide variations in care across the country, high numbers of medical errors and medical practice which is often not based on scientific evidence. At the same time, our country spends approximately 16% of its gross domestic product on health care, and according to recent studies, an estimated 30% of health care expenditures are the result of poor quality care. Dartmouth research has confirmed that quality of care is worse in areas of higher utilization and spending. Moreover, reduced productivity due to absenteeism purportedly has cost our country an additional $105 - $210 billion per year.

In 2001, the IOM stressed in its report, *Crossing the Quality Chasm*, that transparency should be a key element of any strategy to improve clinical quality and achieve better value in the health care system. As consumers become increasingly involved in making decisions about the health care treatment they receive, more reliable and useful data on services provided by physicians and hospitals will enable them to make more informed decisions about where to seek care and assure that the care they receive meets their individual needs. Additionally, more information, which can help consumers choose physicians and hospitals which deliver value-based care, can result in significant savings across the health care system.

Various stakeholders representing a variety of constituencies are advancing transparency initiatives. Last August, President Bush signed Executive Order 13410 "Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs," which requires federal health programs to make quality and price information available to consumers. Additionally, more and more states make quality and cost information publicly available. At least 25 states make health care data available through dedicated websites, including a Florida state website where consumers can access quality, price and performance data on certain conditions and procedures at state hospitals and ambulatory (outpatient) surgery centers. At least 39 states and the District of Columbia have laws that require hospitals and in some cases, other providers to report financial information for health care services.

Health insurance plans have taken important steps – working with physician groups, hospitals, consumers, employers and government representatives through the AQA alliance and the Hospital Quality Alliance – to address gaps in quality and promote transparency of results and decisions by developing uniform processes to evaluate and report on care delivered to patients, and enable practitioners and hospitals to determine how their performance compares with their peers in similar specialties or other hospitals. AHIP also is an active member of the recently created Quality Alliance Steering Committee, convened by HHS Secretary Leavitt, which is assisting and providing recommendations to the Administration as it implements its broader health care transparency initiative.

Our community has made a commitment to working collaboratively with other stakeholders to promote a transparent, value-based health care system. As we participate in these various initiatives, we will advance the following principles:

Supporting a uniform approach for the disclosure of relevant, useful, actionable and understandable information to facilitate consumer decision-making and choice. Information should be made available to enrollees to permit accurate comparisons of physicians, hospitals and other practitioners. Additionally, information should be disclosed and displayed in a format that is easily accessible and understandable; consumers should be educated on how to use the information as appropriate.

Supporting efforts that advance transparency while preserving competition and basing analyses on objective, agreed-upon measures. Consumers and purchasers need accurate information to make more informed health care decisions. At the same time, the disclosure of this information should comport with antitrust guidelines to ensure that vigorous competition continues to thrive in the marketplace. To achieve this objective, ranges – such as the 25th percentile and 75th percentile of payments to hospitals which are disclosed by Medicare – should be the model for disclosing price information.

Recognizing the importance of linking quality and cost of care. Disclosure of information about the quality of care which physicians and hospitals provide and costs of services is important to enable consumers and purchasers to evaluate their health care options, and to enable practitioners to learn how their practices compare to their colleagues' practices in terms of effectiveness and efficiency. At the same time, consumers need assistance in interpreting this information and using these data to make informed decisions.

Developing the tools to analyze high-utilization, high-cost services or conditions where variation exists. The nation needs to build the capacity to analyze certain agreed-upon episodes of care as well as certain services or procedures. Presenting data on episodes of care (*e.g.*, pregnancy) – rather than merely on services (*e.g.*, labor and delivery) – will allow consumers to make more comprehensive and informed assessments. The episodes of care selected should align with conditions which address areas where practice variation exists, have high utilization rates and are known to be cost drivers.

Supporting the disclosure of information for physician as well as hospital services. To promote continuity of care and prevent the proliferation of silos within the health care system, stakeholders should advocate for the disclosure of physician performance information as well as the disclosure of hospital performance information. Disclosure of information for other providers – such as nursing homes and home health agencies – also should be considered.

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Health chief for state gets cold shoulder

GREGG ERICKSON
COMMENT
(02/24/08 00:45:03)

Karleen Jackson, who heads the Department of Health and Social Services, is the boss of 3,500 employees, supervises a budget of $2 billion, and is responsible for the health and well-being of every Alaskan.

Oh, and one other thing. Jackson and her $2 billion budget are in trouble.

Jackson is a pleasant, soft-spoken woman with a doctorate in human services who appears younger than her 55 years. Jackson's problem is that she has lost credibility with the Republican legislators with the most experience in dealing with her department's budget, the same legislators who in the past were the department's most important advocates in the House and Senate.

"I used to have tremendous trust in the department," Rep. Mike Hawker told me last week. For six years Hawker has chaired the House Finance subcommittee that reviews the department's budget: "When you have someone's trust, you can talk and speak about issues without it becoming a political hot potato. ... We're definitely feeling a trend towards having to fight in a more combative relationship with the department for information that used to just be much more forthcoming."

For years Lyda Green, now the Senate president, chaired the Senate's budget subcommittee. Her assessment isn't as blunt as Hawker's, but tends in the same direction. She says the leadership issue at DHSS is a symptom of a larger problem: "There is kind of a pervasive uncertainty about where authority or responsibility lies. That's kind of unsettling."

To analyze the sources of Jackson's troubles one must understand where they fit into the three P's -- policy, politics and personalities. All three are implicated in Jackson's tribulations.

Anyone who's attended House subcommittee hearings on departmental budgets knows that the chamber's Republicans, led by House Finance Co-Chair Mike Chenault, believe their battle to keep a lid on the operating budget will be won or lost during years when the state is flush with cash. It's easy to preach budgetary restraint when oil prices are low, but a much tougher sell when oil prices are nudging past $100 per barrel. "If you let these programs expand, it gets in the base budget, and you have the devil's own time getting it out," Chenault says.

"Now is the time to shore up the foundations, not add new wings to the building," adds Hawker, repeating one of his favorite budget mantras. From that policy perspective, he and fellow Republicans who control the House are skeptical of any request that goes beyond maintaining the status quo in services. Unfortunately for Jackson, what Hawker believes he found when he dug into the budget for Medicaid, the state-federal program providing medical services to the poor, was a budget padded with $30 million that Jackson now acknowledges she doesn't need.

Jackson says the Medicaid request seemed reasonable when it was formulated back in December, but things change. "I am learning more and more about our budget every day," she told me in an

interview, laughing. "I suspect I'm going to learn more things that are in there that I don't know about, as time goes on."

For Hawker, though, it is one more piece of evidence that the department has lost its focus: "I'm very concerned about a loss of business orientation to our budget process. Like this (Medicaid issue), it creates an aura of distrust."

There are personality issues as well, including legislative dismay over the departure in January of Janet Clarke, the department's former chief of finance and administration. Legislators say Clarke was forced out, an allegation Jackson denies, and on which Clarke has declined comment. Clarke is now assisting Hawker on budget issues.

And don't forget the politics. Gov. Sarah Palin is surfing on public approval ratings in the 85 percent range, but the same poll among Republican legislators would likely find 85 percent disapproval. Among the reasons is a perception, also common among lobbyists and many career state officials, that Palin doesn't care about the unglamorous side of government.

Few tasks in state government are less glamorous than the work of Health and Social Services, but it is an area legislators may be focusing on in the weeks ahead. Where that attention will take them is uncertain, but it is unlikely to be pleasant for the woman who runs the department or the governor who is her boss.

Economist Gregg Erickson is the owner of a Juneau consulting firm (www.EricksonEconomics.com).

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Here's one way to cut health care costs, improve quality

COMPASS: *Other points of view*

By GOV. SARAH PALIN

(02/25/08 00:54:58)

Health care: Do we have too much government or too little? Should we have regulated markets or open markets?

Those are the perennial questions.

And that's what makes the state's proposal to repeal the current Certificate of Need (CON) program so contentious. Yes, there are solid arguments on both sides. But after much consideration, we believe that the program has not accomplished what it set out ultimately to do more than 30 years ago -- lower costs for the consumer. It is time to end Alaska's program in its present form. Doing so will not only reduce the cost of health care, it will also improve the access to health care, allow more competition and improve quality of care for patients

Certificate of Need programs were required in all states in the mid-1970s by federal mandate. The goal was to make sure that health care facilities matched community need and provided access and quality care, which in turn would help reduce health-care costs. The federal mandate was repealed in 1987 -- 20 years ago! -- along with its federal funding.

The basic assumption in those days was that excess capacity, in the form of overbuilding, directly results in health-care price inflation. However, after more than 30 years of such programs, the National Conference of State Legislatures has found that there is no solid proof that the state-sponsored CON programs have actually controlled health-care costs. In fact, in 2004 the Federal Trade Commission and the Department of Justice both asserted that these programs actually contribute to rising prices because they inhibit competitive markets.

Many opponents of CON programs have argued that health-care facility development should be left to the economics of each institution, in light of its own market analysis, rather than being subject to political influence.

My administration agrees.

I included repeal of Alaska's current program in my proposed Alaska Health Care Transparency Act (SB 245 and HB 337). The legislation will help Alaskans access affordable health care, and ensure our health-care system is responsive to changing demographics and market conditions. By getting information about health-care options to Alaskans, they can make better choices based on the health-care market.

The Certificate of Need is being used by lobbyists and health-care organizations to limit competition -- through appeal of other's certificate awards or by filing suit against the state for those awards. As one member of a citizen committee studying CON in 2007 put it: "the only voices heard (testifying for continuing CON even more stringently) were from the financially vested physicians and hospitals." Currently, there are seven active Certificate of Need lawsuits involving the state and private sector health-care providers

As I said recently in my State of the State Address to the Legislature, "Under our present Certificate of Need process, costs and needs don't drive health-care choices -- bureaucracy does. Our system is broken and expensive." Eliminating the CON program, with certain exceptions, will allow free- market competition and reduce onerous government regulation.

Sarah Palin is governor of Alaska.

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Michael G. McNamara, MD

Robert R. Thomas, MPAS, PA C, ATC

Feb 7, 2008

To: Representative Peggy Wilson and the HESS Ctte members

Re: House Bill 337 and House Bill 345, Committee meeting Feb 9th

For the record, I am Dr Mike McNamara an orthopaedic hand surgeon and the President of an advisory group that represents 26 limited surgeon partners to the Alaska Surgical Center in Anchorage Alaska.

I am in OPPOSTION to repealing the CON. My four comments deal only with this issue.

In discussing the CON, the purpose for the CON needs to be remembered. It was designed to prevent excessive, unnecessary and duplication of development.

First let me say, as many others that have already testified, I am very disappointed that the Governor and her staff have not paid more attention to the recommendations made by the Task Force for Negotiated Rule Making regarding the CON. It is my understanding over $50,000 was spent on mediation of a 5 day 21 member board that recommended overwhelmingly that the CON not be repealed.

Point two: In Anchorage the primary surgical centers include Alaska Regional, Providence, Alaska Surgical Center, and Alaska Spine. All of these centers are not to full capacity. The Alaska Surgical Center, was operating at only 55- 60% capacity this past year. We are fortunate in Anchorage to have Surgical Centers of Excellence. We have some of the best surgeons, nursing and support staff in the state. Many of the surgeons in Anchorage may even be the best in the country. Our community is thankful for this. Allowing additional surgical facilities to develop when our present centers are not to capacity would likely reduce vital PEER OVERSIGHT which exists in these centers of excellence, and may allow loss of appropriate STANDARDS OF CARE.

Point three: There is a national shortage of OR nursing, and all of these centers are under-staffed with respect to specialized OR nursing and OR support staff. Removing the CON in Alaska would create undo competition for OR staff and specialized skilled nursing where there is already a critical shortage. Competition will not lower costs, but will create greater costs in overhead while competing for these limited resources.

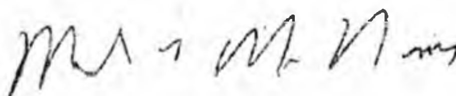
2841 DeBarr Road, Suite 23
Anchorage, AK 99508

Lastly, the larger centers, as they exist, have the power to negotiate contracts with insurance companies and unions, thus allowing reduced costs to the public. Un-checked development would likely reduce the negotiating power of existing centers and additional centers would drive the price of care upward. Un-checked competition in medicine, especially in Alaska, does not equate to reduced prices like the non-medical business models!

Madame Chair and members of the committee, I would urge you to NOT REPEAL the CON. Do not risk loosing the awesome "Center of Excellence" approach to health care that we presently have working well for us in Alaska, at the risk of compromising standards of care. Remember, it was only several years ago that specialty care was sent out to Mayo Clinic, Seattle or other centers of excellence. We now have our own "centers of excellence" with exceptional surgeons in our own great state of Alaska.

Thank you for your attention and consideration with this vital issue. I plan to testify before the House on Feb 9th regarding the CON.

Sincerely,



Michael G. McNamara MD
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2841 DeBarr Road, Suite 23
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Contact Info: W 907 771-3500
C 907 227-5667
mmcnamara@akhanddoc.com

Subject: Eliminate the Certificate of Need 2/5/08 HB 337, SB 245

From: Carter Crawford 107 Maple Dr. Fairbanks Ak. 99709
347-9223 cell

I have just read Mike Power's editorial describing in excellent detail the challenges facing the Fairbanks medical community to provide quality medical personnel. He goes to great lengths to detail how Fairbanks Memorial Hospital has made this a community effort, presumably for the benefit of all clinics.

He fails to point out, however, that the biggest clinic is about to merge into the Hospital, that all clinics use FMH, so 99% of the benefits of team recruiting go to FMH. And of course he makes no mention of the $9 million profit sent to parent Banner Health last fiscal period, or that all recent additions like the Imaging Center and Cardiac Wing are extremely profitable under any circumstances

I have a 25-year history of support for Fairbanks Memorial Hospital, as an in and outpatient and Auxiliary Volunteer. However I find the CON outdated, outrageous and bad policy.

The original purpose of cost containment has long since been eliminated, and Fairbanks Memorial Hospital/Banner Health has arbitrarily replaced it with political protection for their monopoly. It now protects FMH so well that they sent $9 million in profits to parent Banner Health last year while denying any other facility to build.

CON was not intended to insure a profitable non-profit monopoly.

CON was not intended to kill private enterprise

CON was not supposed to reduce quality of medical service and create lengthy delays and increase patient costs.

But CON does all of these in Fairbanks, and from personal experience the past two years.

I have heard potential physician recruits turn down jobs in Fairbanks because of the lack of surgical facility choices. He has intentionally well covered the other reasons, but purposely omitted this one.

My internist quit private practice to work at the hospital leaving numerous patients without a physician. Had there been another clinic with surgical suites, she might have selected it and many patients could have followed her. There were several reasons, but the time spent on administrative work was clearly high on the list.

4-8 week delays for outpatient surgery. It was scheduled about 4 weeks out and had to be rescheduled due to a day of emergency and rescheduled another 4 weeks out.

Surgical error while performing carpel surgery, which has caused permanent damage to my hand. The hall looked like the DMV, but with patients on gurneys, all waiting for surgery.

And my stories are minor compared to the lost x-rays, x-rays of the wrong wrist, 4 day waits to set bones, delivery of wrong meds, too early release, refusing mammograms to those without insurance, ignoring or refusing doctors orders (one time the doctor happened by and I wish I had been there).

One significant argument for CON used by FMH is they would be left with all the no insurance patients. That is preposterous. Both the outpatient proposals to the state recently have agreed to take a portion of no pay clients. And if there is an alternative service the hospital can send no pay patients to they most certainly do. For a mammogram FMH will send you to Breast Cancer Detection Center the second they hear "I have no insurance." And I might ad, BCDC had hired a mammography technologist from outside, offered her a 50% moving allowance and a nice bonus which she accepted: but FMH recruited her, offered full moving and a better bonus.

FMH would lead you to believe they have all the no pay patients and nothing is farther from the truth. The clinics take them, BCDC takes them, and I am sure my Nurse Practioner is not alone in taking them.

But we have no alternative.

It is incredible that the state and our legislators, based on state legislation even the federal government has eliminated, allow a monopoly to continue and deny one of America's most basic principals, FREE ENTERPRISE, to dictate market conditions.

THE STATE DOES NOT OPERATE ON SOLE SOURCE BIDS for the most part, why must Fairbanksans in need of medical service?

In closing, none of the arguments presented by Fairbanks Memorial Hospital to keep CON are valid.

We have a growing population, now close to 100,000

The demand far exceed availability, with 4-8 week waits for outpatient surgery

The costs are much higher than Anchorage. One local Union testified at the public hearing here last year that they were flying patients to Anchorage for treatment because it was cheaper, including the fare, to do so

PREPARED STATEMENT OF
THE FEDERAL TRADE COMMISSION

Before the

STANDING COMMITTEE on HEALTH, EDUCATION & SOCIAL SERVICES

of the

ALASKA HOUSE OF REPRESENTATIVES

on

House Bill 337, "An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; relating to the certificate of need program for certain health care facilities; and providing for an effective date."

February 15, 2008

I. Introduction

The Federal Trade Commission (FTC) is pleased to have the opportunity to discuss health care competition, Alaska's certificate of need (CON) laws, and Alaska House Bill 337 (H.B. 337), which would modify certain of Alaska's CON laws.[1] The Commission believes that CON laws such as Alaska's can be a barrier to entry to the detriment of health care competition and health care consumers, and that the legislature should consider their repeal. The Commission's conclusion is based on the joint FTC/Department of Justice (DOJ) report, *Improving Health Care: A Dose of Competition* (Report or FTC/DOJ Report),[2] its underlying research, and recent work by FTC staff and the staffs of our sister agencies, such as DOJ and the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services. As noted in the FTC/DOJ Report, "[t]he Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[3]

Congress has charged the Commission with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[4] Pursuant to its statutory mandate, the FTC seeks to identify business practices and regulations that

[1] The FTC initially was invited to submit testimony regarding H.B. 337, as introduced on January 22, 2008, which would have repealed Alaska's CON requirements generally; a more recent committee substitute draft also before the relevant Alaska house committee (but not yet available publicly) would repeal only certain of Alaska's CON requirements, but leave others – such as those regarding nursing homes – intact.

[2] FEDERAL TRADE COMMISSION & THE DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July, 2004) [hereinafter "IMPROVING HEALTH CARE"].

[3] *Id.* at Executive Summary, p. 22.

[4] Federal Trade Commission Act, 15 U.S.C. ' 45.

impede competition without offering countervailing benefits to consumers. For several decades, the FTC and its staff have investigated the competitive effects of restrictions on the business practices of health care providers.[5] Included in that general body of health care competition work have been hearings, studies, and reports addressing issues raised by CON laws.

Specifically, the FTC/DOJ Report discusses critically the role of CON laws in health care competition, both as a distinct policy issue and as an important component of other health care competition issues, such as entry problems in hospital markets. The Report broadly examined the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying the preferences of Americans for high-quality, cost-effective health care. The Report was based on, among other things, joint FTC/DOJ hearings that took place over 27 days from February through October 2003, following a Commission-sponsored workshop on health care issues in September 2002. The FTC and DOJ heard testimony from about 240 panelists, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from antitrust and economics to health care quality and informed consent. Together, the hearings and workshop elicited written submissions from interested parties. Almost 6,000 pages of transcripts of the hearings and workshop and all written submissions are available on the Commission website, www.ftc.gov. In addition, FTC and DOJ staffs undertook independent research for the Report.

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[5] *See* Federal Trade Commission, *FTC Antitrust Actions in Health Care Services and Products* (Oct. 2003), *available at* http://www.ftc.gov/bc/hcupdate031024.pdf.

In this testimony, the Commission focuses specifically on a few of the issues discussed in the Report that address CON laws and new entry into competition among health care facilities. Three main points require attention:

- First, vigorous competition among healthcare providers, such as hospitals, clinics, and nursing homes, usually benefits consumers through better and more varied services and, in some cases, lower prices. CON laws were designed to create barriers to entry for new healthcare facilities or providers to contain the costs of healthcare services. CON laws, however, have not been particularly effective in controlling healthcare costs, while posing significant risks to competition. In particular, CON laws can retard the entry of firms that could provide higher quality services or lower prices than those offered by incumbents, depress consumer choice between qualitatively different treatment options or settings, or reduce the pressure on incumbents to improve qualitative aspects of their own offerings. Policymakers would be wise to consider reviewing all of the actual costs, benefits, and consequences – intended and unintended – of a regulatory system when assessing that system's future.
- Second, the CON regulatory system creates both the incentive and means by which an incumbent healthcare provider can use the regulatory system itself to delay effective competition, independent of the demand for additional healthcare services. This additional loss of competition is another regulatory cost that must be weighed in the balance when assessing the public interest.

- Finally, Alaska currently has one of the most stringent CON laws in the United States. House Bill 337's proposed amendment of this law would eliminate or reduce barriers to entry for a broad range of healthcare service providers, including small entities that might then be able to thrive as never before.

These points are addressed more fully, below.

II. Discussion

A. Provider Competition Generally: Competition has important benefits in health care services markets, just as it has in the multitude of markets in the U.S. economy that rely on competition to maximize the welfare of consumers. Competitive pressures can lead hospitals and other entities to lower costs, improve quality, and compete more efficiently. In particular, competitive pressure may spur new types of competition. In some hospital markets, new entrants specialize and provide only a limited portion of the in-patient and out-patient services that general hospitals tend to provide.[6] Elsewhere, health care services once delivered only in large hospitals – and requiring overnight stays – may be performed more conveniently and less invasively, at lower cost, in outpatient settings. In addition, both traditional providers and new entities have explored new means to expand access to basic health care by, for example,

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[6] *See generally Prepared Statement of the Federal Trade Commission, Before the S. Subcomm. On Federal Financial Management, Gov't Information and Int. Security of the S. Comm. on Homeland Security and Governmental Affairs, on New Entry Into Hospital Competition* (May 24, 2005) (regarding, e.g., new specialty hospital entry), *available at* http://www.ftc.gov/os/2005/05/052405newentryintohospitalcomp.pdf; *see also* UNITED STATES DEPT. OF HEALTH AND HUMAN SERVICES, FINAL REPORT TO THE CONGRESS AND STRATEGIC IMPLEMENTING PLAN REQUIRED UNDER SECTION 5006 OF THE DEFICIT REDUCTION ACT OF 2005 (2006) [hereinafter "HHS FINAL REPORT"], *available at http://www.cms.hhs.gov/PhysicianSelfReferral/06a_DRA_Reports.asp.*