Bill as Introduced

HB 169-FN – AS INTRODUCED

2001 SESSION

01-0006
01/09

HOUSE BILL ***169-FN***

AN ACT repealing the certificate of need law.

SPONSORS: Rep. Marshall Quandt, Rock 20; Rep. Weyler, Rock 18

COMMITTEE: Health, Human Services & Elderly Affairs

ANALYSIS

This bill repeals the certificate of need law.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

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STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand One

AN ACT repealing the certificate of need law.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Reference Deleted. Amend RSA 126:26 to read as follows:

126:26 Data Review. The department of health and human services shall [~~provide access, without restriction, to the data collected under RSA 126:25 to the health services planning and review board. The department shall~~] prepare a report ***relative to the data collected under RSA 126:25, I*** on or before November 15, 1996, and annually thereafter, to the speaker of the house of representatives and president of the senate. The report shall contain, but not be limited to, an analysis and evaluation of the data collected and recommendations for improved efficiencies and for health care cost containment. The department of health and human services is also authorized to prepare periodic reports on price and utilization of health services for the purpose of encouraging competition.

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Notwithstanding any other provision of law, all information required to be filed under this subdivision[~~, with the exception of confidential commercial and financial information as defined in RSA 151-C:2,~~] shall be made available:

3 Reference Changed. Amend RSA 126:29, IV to read as follows:

IV. In addition to any other penalties provided by law, any provider required to provide data under RSA 126:25, [~~II~~] ***I***, who willfully fails to comply with the provisions of this subdivision shall be subject to a civil penalty of $50 for each day of noncompliance, which shall not be reimbursable by any commercial insurer, nonprofit health services corporation, health maintenance organization, or multiple employer welfare arrangement as provided in RSA 415, 420-A, 420-B, and 415-E.

4 Reference Deleted. Amend RSA 126:30 to read as follows:

126:30 User Fees. Any person[~~, other than those covered by the fee provisions of RSA 151-C:15, I,~~] requesting copies of data or statistical information filed with the department of health and human services under RSA 126 or RSA 141-B shall pay to the department a fee established by the commissioner of health and human services pursuant to RSA 126:27, IV. The fee shall reflect the full costs of preparing the data for release, including the cost of personnel time, computer and any related expenses associated with fulfilling the request. Fees paid under this section shall be deposited into a revolving account which shall not lapse and shall be used in administering the responsibilities of the department of health and human services under this subdivision.

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(a) Hospitals, [~~as defined in RSA 151-C:2,~~] and infirmaries or health services maintained by an educational institution. ***For the purposes of this subparagraph "hospital" means an institution which is engaged in providing to patients, under supervision of physicians, diagnostic, and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of such persons. The term "hospital" includes psychiatric and substance abuse treatment hospitals.***

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XI. "Facility" means a hospital as defined in RSA [~~151-C:2, XX~~] ***151:2, I(a)***.

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XII. "Nursing home," notwithstanding any other provision of law to the contrary, means any nonprofit or charitable institution or organization, public or private, which is exempt from federal taxation pursuant to section 501 of the United States Internal Revenue Code of 1986 as amended, and which is engaged in the operation of, or formed for the purpose of operating, a facility in which nursing care, sheltered care, intermediate care, life-care or continuing care, and medical services are prescribed by or performed under the general direction of persons licensed to practice medicine or surgery in New Hampshire, and in whole or in part is, or shall be upon completion, [~~(a)~~] licensed as a residential care facility under RSA 151:2, I(e) or [~~(b) can be upon receipt of a certificate of need under RSA 151-C~~] licensed as a nursing home under the laws of New Hampshire.

8 References Deleted. Amend RSA 281-A:2, XII-b to read as follows:

XII-b. "Health care provider" as used in this chapter includes doctors, chiropractors, rehabilitation providers, health services [~~as defined in RSA 151-C:2, XVIII~~], health care facilities [~~as defined in RSA 151-C:2, XV-a~~], and health maintenance organizations [~~as defined in RSA 151-C:2, XVI~~].

(a) For the purposes of this paragraph:

(1) "Health services" means clinically related diagnostic, treatment, or rehabilitative services, as well as preventive services, and includes, without limitation, alcohol, drug abuse, and mental health services.

(2) "Health care facility" means hospitals, ambulatory surgical facilities, specialty hospitals and licensed nursing homes including all services and property owned by such. Health care facilities shall include facilities which are publicly or privately owned or for-profit or not-for-profit, and which are licensed or required to be licensed in whole or in part by the state.

(3) "Health maintenance organization" means a public or private organization, organized under the laws of any state or the federal government which:

(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency and preventive services, and out-of-area coverage; and

(B) Is compensated, except for co-payments, for the provision of the basic health care services listed in subparagraph (3)(A) to enrolled participants on a predetermined periodic basis without regard to the date on which health care services are provided; a predetermined periodic basis shall be fixed without regard to the frequency, extent, or kind of health care service actually provided; and

(C) Provides physician services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through arrangements with individual physicians or one or more groups of physicians organized in a group practice or individual basis, or (iii) a combination of (i) and (ii), as provided herein.

9 Reference Changed. Amend RSA 318:29, V(i) to read as follows:

(i) Any ownership or control of an ownership interest of a pharmacy within the state by an individual licensed to prescribe medicine, or a corporation, professional association or partnership consisting of such prescriber or prescriber's immediate family members, except such corporations as are expressly exempt from income taxation under section 501(c)(3) of the United States Internal Revenue Code. This shall not include ownership of investment securities purchased by the practitioner on terms available to the general public and which are publicly traded. This subparagraph shall not apply to the ownership or control of an ownership interest of an institutional pharmacy operated within the state by or for hospitals, as defined in RSA [~~151-C:2, XX~~] ***151:2, I(a)***, licensed by the state pursuant to RSA 151.

10 Reference Deletion. Amend the introductory paragraph of RSA 326-B:17, IX(a) to read as follows:

IX.(a) The administration of medications by any person employed or under contract to provide direct care to residents of a hospice house [~~as defined in RSA 151-C:2, XIX-b and~~] licensed under RSA 151 and rules adopted under that chapter as a hospice house under the supported residential care level of care by the New Hampshire department of health and human services who:

11 New Subparagraph; Definition Added. Amend RSA 326-B:17, IX by inserting after subparagraph (b) the following new subparagraph:

(c) For the purposes of this paragraph, "hospice house" means a free standing 24-hour residential setting licensed under RSA 151 as a supported residential care facility for terminally ill individuals with less than one year to live who no longer have a home or cannot remain safely there. Palliative care such as room, meals, personal care, medication monitoring and emotional support, is provided. Additional health care services may be provided to residents through arrangements with outside organizations as is currently available if the resident was in his or her own home.

12 References Deleted. Amend RSA 508:18 to read as follows:

508:18 Liability Limited; Health Care Facilities and Personnel.

I. No health care facility ***licensed under RSA 151***, licensed physician, registered nurse, certified physician's assistant or qualified medical technician or medical technologist ordered by a

law enforcement officer to perform a test, medical examination or procedure on a person in the custody of such officer, shall be held liable for any damage arising out of the performance of such test, examination, or procedure, if the test, examination, or procedure is performed with ordinary care. Nothing in this section shall be construed to legalize an otherwise illegal test, examination or procedure insofar as the law enforcement agency and any employee thereof is concerned.

II. For purposes of this section, "health care facility" means [~~"health care facility" as defined in RSA 151-C:2, XV-a~~] ***hospitals, ambulatory surgical facilities, specialty hospitals and licensed nursing homes including all services and property owned by such. Health care facilities shall include facilities which are publicly or privately owned or for-profit or not-for-profit, and which are licensed or required to be licensed in whole or in part by the state.***

13 Repeal. The following are repealed:

I. RSA 126:25, II, relative to a plan developed by the health services planning and review board.

II. RSA 151-C, relative to certificate of need review of proposed new institutional health services.

14 Effective Date. This act shall take effect 60 days after its passage.

LBAO
01-0006
1/5/01

HB 169-FN - FISCAL NOTE

AN ACT repealing the certificate of need law.

FISCAL IMPACT:

The Office of Legislative Budget Assistant is unable to complete a fiscal note for this bill as it is awaiting information from an agency.

Amendments

Rep. Marshall Quandt, Rock 20
January 19, 2001
2001-0024h
01/09

Not Adopted

Amendment to HB 169-FN

Amend the title of the bill by replacing it with the following:

AN ACT adding a duty to the task force on the certificate of need statute and repealing the certificate of need law.

Amend the bill by replacing all after section 13 with the following:

14 Task Force on the Certificate of Need Statute; Duty Added. Amend RSA 151-C:16, V to read as follows:

V.*(a)* The task force shall investigate issues relating to the operation of the certificate of need statute, RSA 151-C, including, but not limited to, how the regulatory structure affects:

[~~(a)~~] *(1)* The cost of health care services;

[~~(b)~~] *(2)* The availability of and access to health care services;

[~~(c)~~] *(3)* Competition and collaboration among health care providers;

[~~(d)~~] *(4)* The provision of new health care services;

[~~(e)~~] *(5)* The allocation of health care resources in the state; and

[~~(f)~~] *(6)* The quality of health care.

(b) The task force shall also determine which sections of the certificate of need statute could be transferred to the department of health and human services, with particular emphasis on provisions relating to nursing homes and rural hospitals.

15 Effective Date.

I. Sections 1-13 of this act shall take effect January 1, 2002.

II. The remainder of this act shall take effect 60 days after its passage.

2001-0024h

AMENDED ANALYSIS

This bill requires the task force on the certificate of need statute to determine which sections of such statute could be transferred to the department of health and human services, with special emphasis on any provisions relating to nursing homes and to rural hospitals.

The bill also repeals the certificate of need law on January 1, 2002.

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 169-FN Date 1-16-01

Committee HHS

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Lee Quandt	Exeter	772-3417	Rock 20	✓	
Ken Wexler	Kingston	642-3518		✓	
Mary Ann	Exeter	772 3417	Rock 20	✓	
Nick Varikas	Bedford	622 3670	CON	—	
Dawn Tuzzin	Concord		Task force	—	
Lisa McGunnigle	Concord	225-0900	NHHA		✓

Hearing Minutes

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 169-FN

BILL TITLE: repealing the certificate of need law

DATE: January 16, 2001

LOB ROOM: 205 **Time Public Hearing Called to Order:** 10:00 a.m.

Time Adjourned: 12:10 p.m.

(please circle if present)

Committee Members: Reps. Batula, Marbel, Chabot, Manning, Case, P. Katsakiores, Feuerstein, Pilliod, Dalrymple, Wendelboe, Ruffner, Millham, MacKay, Emerson, Burnham, C. Kane, French, Seldin, Micklon, Harris and Sokol.

Bill Sponsors: Reps. Quandt and Weyler

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

*REP. LEE QUANDT (Sponsor): I support this bill. (He gave a history of the CON process and told of how some states have gotten rid of the CON process.) I will ask to have the bill placed into a study committee to add an amendment. The legislation was entered at the time of the Reagan administration. The costs in New Hampshire have not diminished. I want smaller hospitals to be protected. I think that the CON procedure should be separated from the process. The process, using Rockingham County as an example, takes too long. "I am a flag-waver for competition." We need to look what processes can be transferred to the welfare department. We need to protect the rural hospitals. I would like us to consider a sub-committee. He submitted a letter from Rep. Weyler, the co-sponsor.

CHAIRMAN PETER BATULA: The amendment should be presented to the executive committee and the committee will decide whether or not to have a study committee. Who delayed the process in Rockingham?

REP. QUANDT: Nothing specifically. I had asked the nursing home administrator to attend, but he said no, not while they have a pending request before the CON board.

REP. DANIEL BURNHAM: What is the status of the Task Force?

REP. QUANDT: I don't know.

*MS. ELIZABETH CRORY (Chairman, Health Systems Plan Board): I oppose this bill. I received this packet of information, which I reviewed. She then defended the CON board members, who she said represented the major health care providers, public members, one member that represents the insurance industry and someone from the DHHS's designee. The designee presently is former Rep. Sochalski. (She submitted her packet of information) She then addressed the allegation made by Rockingham County and the delay. Rockingham did ask what was the process. They were told they

needed to have a more detailed plan. There is a task force of 22 members. I suggest that Lori Real come before this committee and give the testimony she gave to the task force. I brought a pamphlet titled "Issue Brief" which I urge all of you to read. I feel the Board works very hard. There are five paid staff members. It is based on the past years' expense. The assessment is paid by the hospitals and other health care providers. The budget is not allowed to exceed $500,000.

REP. ANDRE MARTEL: If collaboration fails, is the Board looking at healthy competition as a means of lowering the health care costs?

MS. CRORY: If there's replication in certain fields, it would increase costs. They system is regulated by the Board.

REP. MARTEL: The technical sub-committee meets?

MS. CRORY: It can be held when they begin the application process.

REP. MARTEL: Are they held before the public?

MS. CRORY: There is an invitation to those that are interested.

CHAIRMAN BATULA: As a member of the task force, would the members be receptive to changing the board?

MS. CRORY: The CON board task force was looking for the input to bring to the legislature. The board is amenable to the changes recommended by the task force.

REP. ALIDA MILLHAM: Is this legislation unnecessary?

MS. CRORY: Yes, I do believe so. This committee should allow this task force to work.

REP. JAMES MCKAY: What's the sense of having a new task force?

MS. CRORY: The task force is working very diligently. We don't need another study group.

CHAIRMAN BATULA: Has a part of the task force met in strategy sessions?

MS. CRORY: Miss Newson, the Chairman of the task force, is compiling the responses to a questionnaire submitted to the members of the task force. I'm not aware that there is any strategy planning.

REP. JOSEPH MANNING: Was a report sent to the Speaker?

MS. CRORY: In December of 2000, a report was sent to the Speaker.

REP. MANNING: This could go on indefinitely. Do task force members want to wrap this up?

MS. CRORY: One of the members wants to focus on the charge of the task force.

REP. BURNHAM: Is the legislation to do with doing away with the CON board?

CHAIRMAN BATULA: Yes, but the sponsor will bring in an amendment to establish a study committee.

MR. NICK VAILAS (CON Board): I support this bill. I would like our sub-committee to use common sense. In New Hampshire, you are paying more than in Massachusetts. We are the healthiest population in the country, yet we pay some of the highest insurance premiums. The system is broken. The CON board does not do any health care planning or review. The task force has good leadership and it's moving in the right direction. If things are not improved, however, I do think that the CON board should be dissolved. Things need to change with some needed competition in some areas and protection of the rural hospitals.

CHAIRMAN BATULA: Would you say the task force is working well?

MR. VAILAS: It would be if there were a timeline for the task force to complete their work.

REP. MARTEL: I haven't seen that the task force has changed.

MR. VAILAS: A fairer process recently focusing on thresholds is insane.

REP. MILLHAM: Are there other variables that cause increased insurance premiums?

MR. VAILAIS: Increased costs come from the issue of using hospitals, which wish to be all things to all people. We need to make physicians friendly. If it's all hospital-based, then it is going to be very expensive. We need to get away from these thresholds. I do not have faith in this task force.

REP. WALTER RUFFNER: What areas are hospitals more difficult to negotiate with?

MR. VAILAS: It is difficult for insurance companies to deal with areas where there is only one hospital or provider.

REP. ROBERT CHABOT: What about emergency care?

MR. VAILAS: We need hospitals, but you don't need to go to a hospital for certain kinds of care.

REP. CHABOT: What hospitals are left with only certain care?
MR. VAILAS: Yes, costs will increase for certain care. The task force is moving in the right direction.

REP. GLORIA SELDIN: How do you choose where you, as a health care recipient, will go? Have you found many surgeons who will help you choose less expensive care?

MR. VAILAS: Surgeons, who have done this, have been forced out.

REP. JOSEPH MANNING: How do we get the task force to make a final report?

MR. VAILAS: I do have faith.

REP. BURNHAM: What's been happening?

MR. VALAIS: Newington opened a room for 6 physicians. Laconia went to the Supreme Court and the hospital bought the project. The physicians no longer own this. Manchester, we partnered with Catholic Medical Center. Claremont is still surviving.

REP. BURNHAM: CMC?

MR. VAILAS: We have partnered with CMC on a 50/50 basis.

REP. MACKAY: You oppose the bill before us?

MR. VAILAS: I feel the task force is working to correct the issues.

REP. BURNHAM: What is the hostile situation at the seacoast?

MR. VAILAS: The hospital has brought in their surgeons to compete with the surgeons who were working with the ambulatory care unit in that area. We need to develop policies to foster collaboration.

MR. CHRIS GALLAGHER (Community Hospital Coalition): I oppose this bill. This task force is a work in process and the rules have not been put in place. There is a need for the protection of the smaller hospitals. It's clear that our system is the least expensive in New England. Health care is different and something is going right in this state. There is a relationship between the CON board and quality health care. The Con board is where these issues are played out. The outcome is a healthy system. Recent studies show that the system works. The system needs to be altered to be better. The task force needs to continue. There are situations where competition is counter-productive. How do we allocate resources? The CON board is the transitional group that works between government and private markets. Everyone is frustrated with the thresholds. Trust in the task force. The answer is collaboration that doesn't shut out the consumer.

REP. MARTEL: Are there states where they've retained the CON and others where they have relegated the CON process to their legislators?

MR. GALLAGHER: No, not that I am aware of. The government needs to deal with its' health care issues. There are 26 monopolies in this state. What's happening in other states may not be what needs to happen here.

CHAIRMAN BATULA: Are you aware of any strategy sessions since the task force was legislated, by any members of the task force?

MR. GALLAGHER: I am not aware of any, but I hope they are talking with one another. A strategy will evolve.

REP. MANNING: Has the task force considered that emergency services have been taken away from the hospitals by other providers of emergency services? Has anyone thought of asking those groups to pay a fee?

MR. GALLAGHER: No. each state is unique. The task force will be looking at all aspects.

MS. DAWN TOUZIN NHCA): I oppose this bill. I am on the task force and I am a consumer advocate. I am Chairman of that group. There is, to my knowledge, no state where there is a free market. The task force has checked into other states and looked into what's available in this state objectively. The report shows that the task force is working well. I would like to meet the task force timeline, but it may take longer. I am pro-task force.

REP. HILDA SOKOL: What are the major issues?

MS. TOUZIN: The issue of the insured and uninsured. Access is another issue we cannot control through the task force. I feel that it's important to understand the market and that the financial criteria may need to be adjusted as we proceed. We need to gather data and then, having that information, decide what do we need to change or find a body that would do that more appropriately.

REP. RUFFNER: Is there conflicting testimony from Mr. Vailas and Chris Gallagher on the state of health care in New Hampshire?

MS. TOUZIN: I am confused too.

MR. JOHN D. WALLACE (DHHS): I oppose this bill. It would be inadvisable to preempt the work of the task force. The task force may conclude that the CON process should be dissolved, but that regulation may be necessary. The statute needs to meet an updated legislation. The current statute deals with a market from 20 years ago. The department is concerned that core hospitals need to be protected. The long-term care is where the government picks up two-thirds of the costs. Since 1995, there is a moratorium on nursing home beds. Prior to that, moratoriums on nursing home beds were increasing at a 10% rate. The department, through the regulatory process, needs to limit the number of nursing home beds segment. If not through CON, through some other regulatory process. (He then offered to provide Lori Real to provide a presentation to the committee.)

In a response to a question from Rep. French, Mr. Wallace indicated that in some states, assisted living is also regulated, but not in this state.

MR. BOB DUNN (NH Healthcare Association): I oppose this bill.

Respectfully Submitted,

Margaret A. Case

Rep. Margaret Case, Clerk

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11-13-01 EXEC. Session

Rep Martel –
Sponsor – Rep Quandt

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VOTE ITL
15-4

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01-0006
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(C) Provides physician services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through arrangements with individual physicians or one or more groups of physicians organized in a group practice or individual basis, or (iii) a combination of (i) and (ii), as provided herein.

9 Reference Changed. Amend RSA 318:29, V(i) to read as follows:

(i) Any ownership or control of an ownership interest of a pharmacy within the state by an individual licensed to prescribe medicine, or a corporation, professional association or partnership consisting of such prescriber or prescriber's immediate family members, except such corporations as are expressly exempt from income taxation under section 501(c)(3) of the United States Internal Revenue Code. This shall not include ownership of investment securities purchased by the practitioner on terms available to the general public and which are publicly traded. This subparagraph shall not apply to the ownership or control of an ownership interest of an institutional pharmacy operated within the state by or for hospitals, as defined in RSA [~~151-C:2, XX~~] ***151:2, I(a)***, licensed by the state pursuant to RSA 151.

10 Reference Deletion. Amend the introductory paragraph of RSA 326-B:17, IX(a) to read as follows:

IX.(a) The administration of medications by any person employed or under contract to provide direct care to residents of a hospice house [~~as defined in RSA 151-C:2, XIX-b and~~] licensed under RSA 151 and rules adopted under that chapter as a hospice house under the supported residential care level of care by the New Hampshire department of health and human services who:

11 New Subparagraph; Definition Added. Amend RSA 326-B:17, IX by inserting after subparagraph (b) the following new subparagraph:

(c) For the purposes of this paragraph, "hospice house" means a free standing 24-hour residential setting licensed under RSA 151 as a supported residential care facility for terminally ill individuals with less than one year to live who no longer have a home or cannot remain safely there. Palliative care such as room, meals, personal care, medication monitoring and emotional support, is provided. Additional health care services may be provided to residents through arrangements with outside organizations as is currently available if the resident was in his or her own home.

12 References Deleted. Amend RSA 508:18 to read as follows:

508:18 Liability Limited; Health Care Facilities and Personnel.

I. No health care facility ***licensed under RSA 151***, licensed physician, registered nurse, certified physician's assistant or qualified medical technician or medical technologist ordered by a

law enforcement officer to perform a test, medical examination or procedure on a person in the custody of such officer, shall be held liable for any damage arising out of the performance of such test, examination, or procedure, if the test, examination, or procedure is performed with ordinary care. Nothing in this section shall be construed to legalize an otherwise illegal test, examination or procedure insofar as the law enforcement agency and any employee thereof is concerned.

II. For purposes of this section, "health care facility" means [~~"health care facility" as defined in RSA 151-C:2, XV-a~~] ***hospitals, ambulatory surgical facilities, specialty hospitals and licensed nursing homes including all services and property owned by such. Health care facilities shall include facilities which are publicly or privately owned or for-profit or not-for-profit, and which are licensed or required to be licensed in whole or in part by the state.***

13 Repeal. The following are repealed:

I. RSA 126:25, II, relative to a plan developed by the health services planning and review board.

II. RSA 151-C, relative to certificate of need review of proposed new institutional health services.

14 Effective Date. This act shall take effect 60 days after its passage.

LBAO
01-0006
1/5/01

HB 169-FN - FISCAL NOTE

AN ACT repealing the certificate of need law.

FISCAL IMPACT:

The Office of Legislative Budget Assistant is unable to complete a fiscal note for this bill as it is awaiting information from an agency.

1-16-01

Lee Quandt -

- delay Rockingham County project one year?
- another Study Committee./ mid amendment prior to Exec. Session.

Ms. Crory. - as a member of the current task force - do you think the ~~meeting~~ task force can ~~change~~ make recommendations for change. atmosphere.
Strategy

Valias - monopolies - being addressed by task force.
if the task force fails - then repeal task force

(open mind)
Gallager - Since the task force went into law. are you aware of a part of the task ~~force~~ since meetings to discuss a strategy for the task force.

Dawn Touzin (touzin)

Testimony

January 16, 2001
HB 169 Room 205 10:00 a.m.
Committee on Health, Human Services and Elderly Affairs

Statement of Rep. K. Weyler, Rockingham 18

Ladies and Gentlemen:

One of our most important duties as legislators is to recognize when a program that the legislature created earlier is not working, and then to take action to change or eliminate that program.

Fifteen years ago, the certificate of need process was created so that a neutral party could ensure that scarce resources were not wasted in needless duplication. At its inception, the Health Planning and Review Board may even have had the goal of encouraging competition. I suggest to you that the opposite is now happening, and that the certificate of need process is used to prevent competition.

One of the worst things we can do as policy makers in government is to allow the power of government to be misused to the profit of a few. As I have heard recently, hospital costs in my part of Rockingham County are some of the highest in the country, more expensive than Boston. This has occurred through regional monopolies, monopolies which are maintained by the certificate of need process.

The CON process makes any competitive enterprise go through a lengthy process designed to use up capital and patience. Meanwhile, the requests by an existing hospital get minimal scrutiny. The appointing authority for this board has been unduly influenced to appoint a majority of members that will do the hospital association's bidding.

Their actions are causing revenue loss for Rockingham County. They have delayed approval for an assisted living facility at the Rockingham County complex for over a year. Our delegation is experiencing the same obfuscation that any facility has to undergo that might compete in any way with our existing hospitals and their interwoven health care complexes.

There used to be a CON process at the Public Utilities Commission. They got rid of it. Ladies and gentlemen, for the good of New Hampshire we need to get rid of the process in health care. Listen carefully to those who will defend the CON process. They are all enjoying the fruits of monopoly.

Thank you,

Ken Weyler

Kenneth L. Weyler

ISSUE BRIEF

HEALTH POLICY TRACKING SERVICE

Subject: Providers Title: Certificate of Need	Date: 05/22/2000

By: Elana Mintz

At one time, every state was required by the federal government to have a certificate of need (CON) program. The process was intended to keep down costs associated with th construction of new health facilities in the state, and prevent overdevelopment. When th federal requirement was lifted, however, a number of states did away with their programs. Some later restored it in some form, and many have kept their programs aliv for years, requiring a governmental seal of approval for building new facilities such as hospitals and long-term care facilities or for acquiring major medical equipment.

Federal History

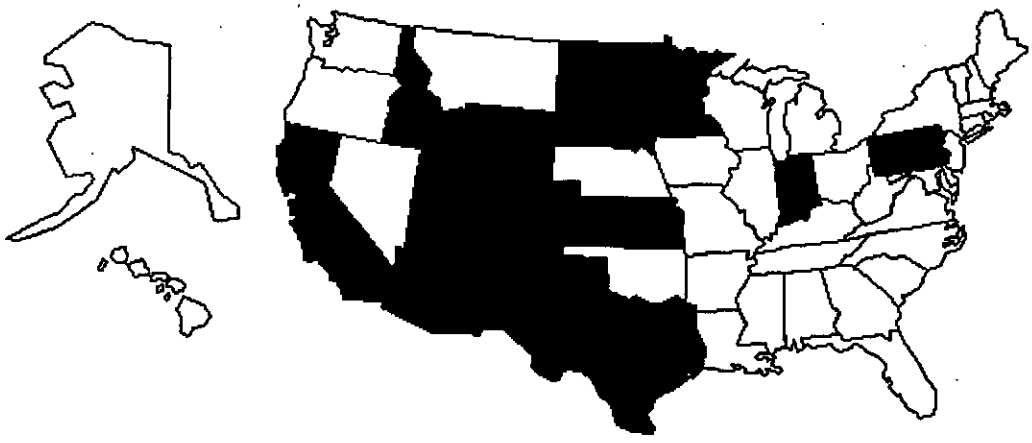
President Ronald Reagan did away with the federal requirement for states to have health planning agencies in 1986. He was not a proponent of the program, having first recommended phasing it out in 1981.

The federal health planning program, created in 1974 (PL 93-641), was intended to stop unnecessary health facility construction and acquisition of expensive major medical equipment. Critics felt the program represented excessive government intervention, while supporters said it helped curbed rising health care expenditures. During the debate in the mid-80s, those who opposed the program said that federal regulatory changes--such as a restructuring of the Medicare payment system--would hold down costs, making a certificate of need program unnecessary.

In 1981, although the Reagan administration recommended a phase-out, Congress chose to continue the program for a year, albeit with funding levels cut substantially. The final version of the bill cleared by the House and Senate called for a one-year extension of the requirement that states have planning agencies, but it reduced federal funding to $102 million for FY 1982, down from a FY 1980 authorization of $157.7 million.

In the summer of 1986, President Reagan signed a $1.7 billion supplemental spending bill (PL 99-349) that included a provision allowing state planning agencies to continue their programs until their fiscal 1986 money ran out. In November 1986, Reagan signed a massive health care bill that repealed section XV of the Public Health Service Act, which had created the program. The provision went into effect Jan. 1, 1987.

States That No Longer Have a Certificate of Need Program



■ States that no longer have CON

Source: Missouri CON program, Health Policy Tracking Service, July 1999

Ramifications of the Federal Repeal for the States

After the federal law was repealed and states no longer were required to maintain a certificate of need program, a number of states repealed their CON laws. Some states phased out their programs even before the federal repeal law was signed.

Currently, 14 states--**Arizona**, **California**, **Colorado**, **Idaho**, **Indiana**, **Kansas**, **Minnesota**, **New Mexico**, **North Dakota**, **Pennsylvania**, **South Dakota**, **Texas**, **Utah** and **Wyoming**--no longer have a CON program *(see map above)*. Some states that still have one, such as **Maine**, **New Hampshire**, **Massachusetts**, and **Missouri**, are considering doing away with it. Two states--**Wisconsin** and **Indiana**--initially abolished their programs but restored certain aspects of their review process, such as the long-term care portion, following repeal of the law. When **Indiana** allowed the long-term care portion of its CON program to lapse in 1998, the state's program died.

In an attempt to ascertain the ramifications for states following repeal of their CON programs, NCSL in 1999 interviewed current and former health department officials in 10 of those states, as well as officials in the two states that restored their programs. The results of those interviews, compiled below, examine how each state fared following the abolition of its CON program.

Please note that this section is not intended as a definitive analysis of the state's program, but rather a view from the perspective of those involved with the process at the state agency level. All the analysts are listed by the division of the health department with which they are or were affiliated:

Arizona
Last year of CON program: 1985
Phil Lopes, former chief, Bureau of Health Systems Development
Lopes says in the early 1980s, the state was involved in what Lopes terms a "nasty political fight" over competing ballot initiatives relating to health costs, pitting the hospital association against certain private companies. He says that when the debate emerged to disband CON, the public turned a deaf ear, exhausted from the previous battle over the initiatives.

Following CON's repeal, there was a rush to construct nursing home and psychiatric beds. Lopes, who "absolutely supported" CON when it was in place, says he believes the state suffered and continues to suffer for repealing the program. But even though occupancy rates are down and there is a plethora of idle beds, he believes it is unlikely that there will ever be a movement to restore the CON program.

Colorado
Last year of CON program: 1987
Susan Rehak, director, Rural/Primary Health Care
The process to remove CON was not a smooth one in Colorado, but without any legislative initiatives to resurrect it that Rehak can recall, there never has been any real possibility of the program being restored. The first movement to bring back CON emerged a year after the program's demise, but that attempt and any after it were defeated.

After CON was repealed, there was a flurry of nursing home and hospital construction, prompting a decrease in occupancy rates. To curb overbedding, the state's Medicaid office placed a moratorium on Medicaid-certified beds in nursing homes in 1990.

Idaho
Last year of CON program: 1983
Richard Schultz, administrator, Division of Health
The CON law in Idaho was short-lived. Enacted in 1980, it had a three-year automatic repeal. According to Schultz, who directed the state's health planning agency when CON was in place, there was a push for its repeal when the debate came up in the legislature. There had never been much legislative support for it and he says the primary reason for its enactment was that the state did not want to be denied federal money.

The extent of any debate to bring the program back comes from a few legislators, but Schultz says there has been no formal movement to restore it. Like other rural states, there is not the demand for construction of new facilities that there might be in more populous states that have larger urban centers. Rural hospitals in the

state, which have lately been downsizing their staffs, are considered to be doing well if their occupancy rates are near 20 percent. In urban areas, average occupancy rates hover between 40 percent and 70 percent.

According to Schultz, CON "didn't seem to have much of an effect" when it was in place and the state has not been affected significantly by its repeal.

Kansas
Last year of CON program: 1985
Richard Morrissey, director, Office of Local and Rural Health
Morrissey says there was not a large-scale fight to keep the program, but there were arguments. Providers supported its repeal and the health department did not take a strong stand one way or the other. In the years that followed, the nursing home industry sought to restore it because a rash of new nursing home beds which resulted in a 10 percent bed increase brought significant competition to the field.

For hospitals, the effect has not been as substantial, according to Morrissey. The number of beds has continued to decrease and most of the hospital construction has involved renovation or building outpatient facilities.

Morrissey says he is not convinced that CON stopped hospitals from placing a greater emphasis on outpatient facilities. As the industry evolves, outpatient facilities represent cost-cutting opportunities.

The number of private psychiatric hospitals increased by eight as a direct result of repealing CON. During the mid-80s, the private psychiatric hospital industry was going through a boom even though the state's department of health did not feel there was a need for so many of them. With CON, Morrissey said, they were able to keep down the number of hospitals. In recent years, that industry has reversed course, and hospitals in Kansas have decreased their work force.

Minnesota
Last year of CON program: 1984
Carol Hirschfeld, supervisor, Program Assurance Unit
With moratoriums in place on Medicaid-certified nursing home beds since 1983 and on hospital beds since 1990, there have been no new beds in Minnesota for years.

Hirschfeld says that although there have been legislative initiatives to alter the moratoriums, restoring CON is not part of the public debate, because there has been no movement in the state legislature to restore it.

New Mexico
Last year of CON program: 1983
Sue Ellen Rael, assistant to the secretary, Department of Health
After CON was repealed, New Mexico maintained a review process until 1987. Rael does not recall that anyone was particularly unhappy with CON being repealed, but says having the process in place helped the health department disperse facilities so that rural areas were not underserved. Rael says the department was able to continue that practice for some years under the modified review process that succeeded CON.

The state has worked to keep costs down, especially those incurred by Medicaid. When the Medicaid program in New Mexico developed a reimbursement plan for the state's nursing homes during the mid-1980s, it reimbursed very little for capital expenditures.

Rael does not recall an inordinate amount of overbedding or major hospital expansion after CON's repeal. As in other states, a changing health care industry has prevented overdevelopment.

North Dakota
Last year of CON program: 1995
Fred Larson, policy analyst, former director of North Dakota CON program.
Larson helped draft CON repeal legislation five times before it was finally enacted. He says that "most people were pretty happy to see it go away" because there had been so many debacles associated with the program over the years.

One of the primary concerns in abolishing the program was how it would affect Medicaid, so the state placed a moratorium on construction of new nursing home beds. The nursing home industry has been supportive of maintaining that moratorium.

The transition has not been without problems. Larson says that construction of new facilities around the state, including medical and private psychiatric hospitals, combined with a diminishing population has had a

significant enough effect on state money to frustrate policymakers.

Still, there has not been any serious debate about restoring CON, and no measures to bring it back have been introduced in the legislature.

South Dakota
Last year of CON program: 1988
Kevin Forsch, director, Health Systems Development and Regulation Division
Forsch says CON was repealed because the process became entangled in the threat of lawsuits by providers who had been denied approval for construction projects. Rather than save the state money, the law lead to legal bills and a heavy financial burden for the state.

Although legislators in recent years have suggested bringing back the program, there has not been a groundswell of support for the idea. Forsch says the downfall of the program was the legal issue. Even providers have changed their stance, and no longer see a need for CON. Forsch recalls the director of a provider association who once commented that "the only ones that really benefitted from [the CON] process were the attorneys."

The year CON was repealed, a moratorium was placed on the construction of new long-term care beds in the state. The repeal will automatically sunset on June 30, 2000, but the law will likely stay in place, because, according to Forsch, it has been credited with saving the state roughly $50 million to $70 million in Medicaid dollars. That is because people who might have moved into nursing homes or other long-term care facilities were able to utilize home and community-based services, which generally are cheaper. The trend toward those services has made the need for long-term beds less urgent. In the meantime, South Dakota's assisted living industry is booming.

Forsch says that, without any consensus within the Legislature or among providers to bring back CON, the program is dead, and will not be resurrected any time in the near future.

Utah
Last year of CON program: 1984
Patrick J. Johnson, executive director, Health Policy Commission
While restructuring of the health care market has served some of the same purposes as CON in preventing overdevelopment in Utah, Johnson wonders if CON might have helped prevent more recent debacles, such as the closing of a hospital owned by Family Health Plan, a California-based HMO, just three years after it opened. With a trend toward renovating or converting existing facilities, a move to keep Medicaid recipients out of nursing homes as long as possible, and an industry need to cut costs where possible, Johnson does not see a renewed public or governmental demand for regulation modeled on the CON review process.

One of the direct results of the law's repeal was a proliferation of private psychiatric hospitals the year after the law was abolished. Those facilities either have closed or been bought out as a result of an overall downsizing of that industry.

A nursing home bed moratorium has been in place since the late 1980s, enacted by the health department without the Legislature's participation. Johnson acknowledges that "there's been some grumbling" about the fact that the moratorium did not go through the Legislature, but says the Legislature was relieved not to have to sort through what could have been a tough political fight. From the health department's perspective, it was important to enact the moratorium to keep Medicaid costs down.

Currently, occupancy rates are not at a level that would compel the state to lift the moratorium, and the state is trying to cut costs by moving the elderly and disabled into home and community-based services.

Wyoming
Last year of CON program: 1985
Douglas Thiede, manager, Office of Rural Health
After federal money for state CON programs was taken away, the Legislature supported the idea of doing away with the program altogether. Although there was some controversy in some of Wyoming's larger cities, he says the only groups that complained were the ones who were being prevented from constructing new or expanded health facilities.

The state's number of long-term care beds went up after CON was repealed, prompting lawmakers to pass a limit on the number of long-term care beds. That law, still in effect, would put the limit in place if more than 92 percent of long-term care beds have been filled for more than three years. If the percentage decreases, more beds could be built. According to Thiede, that is the only real restriction on health planning, and there has never been a movement in the Legislature to restore CON.

In part because of Wyoming's rural geography and because companies are trying to cut costs by shortening

inpatient hospital stays, Thiede says "there's not really much clamoring to build health facilities in Wyoming." Because of that, he believes the program will not be resurrected.

States That Restored Review Process Following Repeal

Indiana
Last year of CON: 1986
Last year of long-term care portion of CON: 1998 *(CON program died after long-term care portion lapsed)*
Tom Reed, public health administrator, Indiana Department of Health
There currently is no formal review process in Indiana because the legislation authorizing the long-term care portion of CON lapsed in July 1998.

As occupancy rates in nursing homes decreased, the health department felt that CON was not as effective as it was intended to be, according to Reed. The program originally lapsed in 1996, when Governor Evan Bayh (D) vetoed a bill that would have renewed CON for two years. Reed says there were about 3,000 new long-term care beds built during that period, bringing the state total to roughly 30,000. After that year, the state restored the review process.

The Department of Health drafted a white paper last year that asserted there was no need for a CON program in the state, saying that marginal facilities would close by themselves and, without a barrier to adding additional beds, competition would come in where it was appropriate.

Reed says that historically, smaller nursing homes (40 beds or less) have had higher levels of deficiency in their survey process, and may have stayed in business longer when CON prevented larger nursing homes from building facilities.

Reed says that although he believes there is general consensus that CON is better off dead, the nursing home industry would like to see it restored. There is an abundance of beds and facilities in the state, and although Reed believes it is more important for the Legislature to spend its time increasing fines for nursing homes with violations, the industry may want to see a market that is not overrun with empty beds.

Wisconsin
Last year of original CON law: 1983
Currently covers: long-term care, intermediate care facilities for the mentally retarded, subacute care
Connie Miller, lead analyst, Resource Allocation Program
Miller says provider groups originally helped do away with the state's CON program. After it initially was abolished, about five psychiatric hospitals moved in and there was increased construction. Eventually, three of those hospitals closed, and a Cost Containment Commission was appointed to evaluate the issue.

Miller says abolishing the remainder of the CON program is "not a big deal" to the Legislature, and providers would like to see it go.

2000 State Activity

States have introduced a range of CON legislation so far this year, from exempting certain health care facilities from review to authorizing an increase in nursing home beds. By the end of 1999, legislatures had introduced several different kinds of CON legislation, including some that called for a complete overhaul of the state's program. **Table 1** tracks 2000 legislation after it has passed one chamber of a state's legislature.

Table 1.
2000 Bills Relating to Certificate of Need*

State	2000 Bill	Description	Passed House	Passed Senate	Enacted (E) or Vetoed (V)
Alabama	--	--	--	--	--
Alaska	H 297	Relocation of ambulatory surgical centers without CON	x	x	4/21/2000 (E)
Arizona	--	--	--	--	--
Arkansas	--	--	--	--	--
California	--	--	--	--	--
Colorado	--	--	--	--	--

Connecticut	S 86	Makes certain changes to CON application process.	--	x	--
Delaware	--	--	--	--	--
Florida	S 1222	Long-term care task force.	--	x	--
	H 591	Deletes CON requirements for Medicare-certified home health agencies. Contains other CON provisions.	x	x	--
	H 2339	Patient Protection Provisions, contains CON provisions.	x	x	--
	H 1993	Long-term care task force with CON on agenda.	x	x	--
Georgia	--	--	--	--	--
Hawaii	--	--	--	--	--
Idaho	--	--	--	--	--
Illinois	SJR 69	Creates Illinois Legislative Task Force on Certificate of Need	--	x	--
Indiana	--	--	--	--	--
Iowa	--	--	--	--	--
Kansas	--	--	--	--	--
Kentucky	HCR 119	CON study committee	x	--	--
	H 452	Continuing care retirement communities	x	x	--
	S 339	Broad hospital bill containing provision on CON.	x	x	4/4/2000 (E)
	S 330	Medicare and hospital bill containing CON provisions.	x	x	4/3/2000 (E)
Louisiana	--	--	--	--	--
Maine	--	--	--	--	--
Maryland	H 864	Conditions for CON for continuing care retirement communities (CCRCs)	x	x	--
	S 403	Exemptions for CON for CCRCs under certain circumstances	x	x	5/11/2000 (E)
	S 146	CON exemptions for CCRCs	x	x	5/11/2000 (E)

Massachusetts	--	--	--	--	--
Michigan	--	--	--	--	--
Minnesota	--	--	--	--	--
Mississippi	H 1386	CON and county-owned hospitals	x	x	Bill moves back to House for concurrence.
	S 2367	CON for health facilities serving poor areas	--	x	--
Missouri	--	--	--	--	--
Montana	--	--	--	--	--
Nebraska	--	--	--	--	--
Nevada	--	--	--	--	--
New Hampshire	S 323	Lowers threshold for review of ambulatory surgical centers.	x	x	5/18/2000: Moves to Senate for concurrence.
New Jersey	--	--	--	--	--
New Mexico	--	--	--	--	--
New York	--	--	--	--	--
North Carolina	--	--	--	--	--
North Dakota	--	--	--	--	--
Ohio	--	--	--	--	--
Oklahoma	--	--	--	--	--
Oregon	--	--	--	--	--
Pennsylvania	--	--	--	--	--
Rhode Island	--	--	--	--	--
South Carolina	S 95	Requires hospices to be subject to CON review.	x	x	5/1/2000 (E)
South Dakota	--	--	--	--	--
Tennessee	H 1637	CON for similar projects	x	--	--
	H 2896	CON exemption for linear accelerator services by certain general acute care hospitals.	x	x	5/18/2000 (E)
	S 2741	Amends CON requirements for mobile MRI facilities.	--	x	--
	H 2986	CON exemption for linear accelerator services in certain health facilities.	x	x	5/18/2000 (E)
	H 2834	CON and nursing home beds.	x	--	--
Texas	--	--	--	--	--

Utah	--	--	--	--	--
Vermont	--	--	--	--	--
Virginia	S 337	Eliminates CON requirements for certain medical facilities	x	x	--
	S 596	Increases bed supply	x	x	--
	H 613	Nuclear medicine imaging	x	x	--
	H 1270	Changes current reference from "health systems" to "health planning" agency. Revises other sections of current law relating to amount of time CON proposals could be under review	x	x	--
	H 326	Increases bed supply for continuing care providers	x	x	--
	H 739	Increases bed supply	x	x	--
Washington	S 6518	Hospice care	--	x	--
	H 3005	Revises requirements for cardiac programs	x	x	3/22/2000 (E)
West Virginia	H 4250	Authorizes Department of Health and Human Resources to promulgate legislative rules relating to CON program.	x	x	--
	H 4579	CON and summary review for certain behavioral health facilities and services.	x	x	--
Wisconsin	--	--	--	--	--
Wyoming	--	--	--	--	--

*Legislation included in this chart has passed at least one chamber of a state's legislature. Summaries of those bills are available on the Health Policy Tracking Service website.

Home

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Modern Healthcare
December 2000

For hospitals, it's location, location

■ By Mary Chris Jaklevic

When it comes to hospital profits, geography constitutes a wild card.

Although hospitals' aggregate total profit margin dropped to 4.7% in 1999, its lowest level since 1994 (Dec. 2, p. 2), profits varied wildly by state. Those with cut-throat urban markets and heavy emphasis on academia, such as Massachusetts, New York, Pennsylvania and Rhode Island, recorded meager margins. States with milder competition and booming economies, such as Wyoming and Virginia, yielded beefier earnings.

The numbers are a reminder that despite national factors such as Medicare cutbacks and a nursing shortage, the nation is really a patchwork of local markets (See chart).

For example, New Hampshire hospitals ranked No. 3 with a 12.1% margin. Just 60 miles south, Rhode Island's 12 hospitals were the least profitable nationwide, with a negative 1.7% margin.

New Hampshire Hospital Association President Mike Hill acknowledges that his state's hospitals are in "pretty decent shape." Among the favorable factors, he says, is an uninsured rate of 9% vs. 17% nationally.

Hill also likes to think that the state's hospitals have historically been efficient operators. "Because we started from that position, managed care had perhaps less of an impact on the hospitals financially than they did in other places that were experiencing enormous drops in utilization," he says.

Medicare restraints enacted as part of the Balanced Budget Act of 1997 have hurt, Hill says. In 1995, all hospitals in the state posted operating profits, compared with 18 out of 26 last year, he says.

The "saving grace" is private payers, which shell out $1.23 for every dollar's worth of care, vs. 95 cents paid by Medicare, Hill says. New Hampshire hospitals also are "well-distributed," he adds, making it hard for insurers to walk away from a contract.

By contrast, Rhode Island hospitals are getting 2% less than their costs from private payers, says Ed Quinlan, president of the Hospital Association of Rhode Island. He notes that most of the state's hospitals are high-cost teaching institutions, and there is a large elderly population with a high Medicare HMO enrollment.

In fact, the state's hospitals failed to post a profit even though Rhode Island had the highest insurance rate in the nation last year, with 93% of residents holding coverage.

Rhode Island hospitals contend they are footing the bill for an unstable HMO market. Harvard Pilgrim Health Plan, the state's No. 3 HMO, collapsed in early 1999, and Tufts Health Plan, a distant fourth in size, pulled out of the state because of losses, leaving just two large payers.

Plans have increased premiums by as much as 40% in the past two years while offering providers only modest rate increases, Quinlan says. "Some hospitals have even been offered cuts," he adds.

He says the state's hospitals collectively lost $50 million in 1999, and will lose another $50 million this year, despite a $12 million state Medicaid infusion.

Farther south in No. 2-ranked Virginia, good management and a healthy economy helped to generate strong results, says Katharine Webb, senior vice president at the Virginia Hospital and Healthcare Association.

During the past eight years, hospitals in the state formed strong regional systems such as Roanoke-based Carilion, Norfolk-based Sentara and Falls Church-based Inova, which achieved operating efficiencies and market leverage.

"Our hospital executives have really focused on getting ahead of the curve," Webb says.

But she adds that many small independents are posting negative operating margins, and three declared bankruptcy during the last 18 months. She says about one-fifth of the state's hospitals posted negative operating margins last year.

Hawaii, on the other hand, is hoping for a rebound. Its 32 hospitals were the third least profitable.

The state has been in the grips of a recession in the Pacific Basin since the early 1990s, says Rich Meiers, president and chief executive officer of the Healthcare Association of Hawaii. The state's fabled 3.5% uninsured rate has ballooned to more than 10% because of the recession, Meiers says.

Meanwhile, the state's economy is beginning to turn around. "The tourism business has perked up a little bit from the mainland (U.S.," he says.

The local economy is also key in No. 4-ranked Wyoming, where a booming mineral market has showered state coffers with a $132 million surplus, says Robert Kidd, president of the Wyoming Hospital Association. The majority of Wyoming hospitals are tax-supported.

Plus, Kidd says, utilization is low thanks partly to "a sturdy population (of) mostly ranchers" who "don't like to be in the hospital." □

Sitting pretty

States with highest aggregate hospital profit margins in 1999

*Louisiana	15.5%
*Virginia	12.2
New Hampshire	12.1
Wyoming	10.8
Alaska	10.3
Utah	9.8
Georgia	9.6
Idaho	9.0
New Mexico	9.0
South Dakota	8.9

Limping along

States with lowest aggregate hospital profit margins in 1999

Rhode Island	(1.7%)
District of Columbia	(1.5)
Hawaii	(0.8)
New York	(0.8)
Massachusetts	(0.6)
New Jersey	1.3
California	1.9
Arizona	2.0
Maryland	2.3
Connecticut	2.4

*An official of the Louisiana Hospital Association disputed the state's ranking as most profitable, contending that a low response rate by Louisiana hospitals to the American Hospital Association survey might have caused the data to be inaccurate. The Virginia Hospital and Healthcare Association also questioned the accuracy of its ranking.

Note: Data are based on nonfederal, acute-care and other specialty hospitals, including skilled-nursing units. Total margins were calculated using data from the AHA's annual survey of all hospitals released in November. Total margins include investment income, which makes them a less reliable indicator of financial health than operating figures, which were not provided in the AHA report.

Source: American Hospital Association

MH/Janice Prather

Voting Sheets

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on HB 169-FN

1-30-01 HHS voted TO "RETAIN" THE bill

BILL TITLE: **repealing the certificate of need law**

DATE: January 24, 2001

LOB ROOM: 205

Amendments:

Sponsor: Rep. Fran Wendelboe — OLS Document #: *0024h

Sponsor: Rep. — OLS Document #:

Motions: OTP, OTP/A, ITL, (Re-Refer), Interim Study (Please circle one.)

Moved by Rep. Fran Wendelboe — *AMENDMENT #0024h WITHDRAWN BY REP. WENDELBOE & REP. MICKLON

Seconded by Rep. Stephanie Micklon

Vote: 12-6 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: No

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Margaret A. Case

Rep. Margaret A. Case, Clerk

OFFICE OF THE HOUSE CLERK

2001 SESSION

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

Bill #: HB 169-FN Title: _____

PH Date: 01/16/01 Exec Session Date: 01/24/01

Motion: Re-Refer Amendment #: _____

MEMBER	YEAS	NAYS
Batula, Peter L, Chairman	✓	
Martel, Andre A, V Chairman	absent	
Chabot, Robert F	✓	
Manning, Joseph P	absent from the vote	
Case, Margaret A	✓	
Katsakiores, Phyllis M	✓	
Feuerstein, Martin	✓	
Pilliod, James P	✓	
Dalrymple, Janeen A	✓	
Wendelboe, Fran ☆	✓	
Ruffner, Walter D	✓	
Millham, Alida I	~~absent from the vote~~	✓
MacKay, James R		✓
Emerson, Susan	✓	
Burnham, Daniel M		✓
Kane, Cecelia D		✓
French, Barbara C	absent	
Seldin, Gloria		✓
Micklon, Stephanie K ☆	✓	
Harris, Sandra C	✓	
Sokol, Hilda W		✓

☆ Point Persons

TOTAL VOTE: 12-6

Printed: 1/3/2001

12 6

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

Bill #: HB 169-FN Title: Amendment 2001-0244

PH Date: 01/16/01 Exec Session Date: 01/24/01

Motion: OTP Amendment #: 2001-0244

MEMBER	YEAS	NAYS
Batula, Peter L, Chairman		
Martel, Andre A, V Chairman		
Chabot, Robert F		
Manning, Joseph P		
Case, Margaret A		
Katsakiores, Phyllis M		
Feuerstein, Martin		
Pilliod, James P		
Dalrymple, Janeen A		
Wendelboe, Fran		
Ruffner, Walter D		
Millham, Alida I		
MacKay, James R		
Emerson, Susan		
Burnham, Daniel M		
Kane, Cecelia D		
French, Barbara C		
Seldin, Gloria		
Micklon, Stephanie K		
Harris, Sandra C		
Sokol, Hilda W		

Withdrawn mk.

TOTAL VOTE:
Printed: 1/3/2001

EXECUTIVE SESSION

COMMITTEE Health Human Services & Elderly Affairs

BILL NUMBER SB 169

BILL TITLE: Repealing the Certificate of Need Law

DATE: 11-13-01 **LOB ROOM:** _____

Amendments:

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Motions: OTP, OTP/A, (ITL), Re-Refer, Interim Study (Please circle one.)

Moved by Rep. Rep. ~~Lotta~~ Millham

Seconded by Rep. Rep. Seeler

Vote: 15-4 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. _____

Seconded by Rep. _____

Vote: _____ (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: _____

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Margaret A. Case Clerk

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

Bill #: HB 1169 Title: Repealing the Certificate of Need Law

PH Date: 1/1 Exec Session Date: 1/13/01

Motion: ITL Amendment #: 205

MEMBER	YEAS	NAYS
Batula, Peter L, Chairman	✓	
Martel, Andre A, V Chairman	✓	
Chabot, Robert F	✓	
Manning, Joseph P		✓
Case, Margaret A	✓	
Katsakiores, Phyllis M	✓	
Feuerstein, Martin	✓	
Pilliod, James P		✓
Dalrymple, Janeen A	✓	
Wendelboe, Fran	✓	
Ruffner, Walter D		✓
Millham, Alida I	✓	
MacKay, James R		
Emerson, Susan	✓	
Burnham, Daniel M	✓	
Kane, Cecelia D	✓	
French, Barbara C	✓	
Seldin, Gloria	✓	
Micklon, Stephanie K		
Harris, Sandra C		✓
Sokol, Hilda W	✓	
TOTAL VOTE: 15-4	15	4

Printed: 1/3/2001

Committee Report

Majority

COMMITTEE REPORT

1-30-01 HHS votes to "RERER" the bill

COMMITTEE: **Health, Human Services and Elderly Affairs**

BILL NUMBER: **HB 169-FN**

TITLE: repealing the certificate of need law

DATE: 1-24-01 CONSENT CALENDAR YES ☐ NO ☒

☐ OUGHT TO PASS

☐ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☒ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

Vote 12-6

Rep. Fran Wendelboe
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

The committee did not think the certificate of need task force created in the 2000 session has had a sufficient time to adequately study and make recomendations on the continued status of the certificate of need process.
This task force is composed of 20 members representing a broad spectrum of health care entities (and providers), legislators, insurance industry, and the public.

The repeal of the certificate of need board has been a contentious issue debated over the last several years. ~~Because all but one member expressed strong support and confidence in the CON task force, a motion was made of re-referral on the CON repeal to allow another full year for the task force's study of the CON process to continue. This legislation would then be taken up in the 2002 session and with amendments as appropriate.~~

The committee did not think the certificate of need task force created in the 2000 session has had a sufficient time to adequately study and make recomendations on the continued status of the certificate of need process.
This task force is composed of 20 members representing a broad spectrum of health care entities (and providers), legislators, insurance industry, and the public.

The repeal of the certificate of need board has been a contentious issue debated over the last several years. ~~Because all but one~~

There was no question in the mind of the majority that the appropriate action on this bill was not to act on it, other than ~~repeal~~ retain, until we have given the current task force an opportunity to do their work and come back with a recomendation. This legislation would then be taken up in the 2002 session with amendments if that is their decision and task force results. There is no subtle message in this decision other than lets wait until the appropriate time to bring this bill back to committee for a resolution.

MAJORITY

Wendlboe

1-30-01
HHS voted
TO "RETAIN"
THE BILL.

Minority COMMITTEE REPORT

COMMITTEE: HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

BILL NUMBER: HB169 – FN

TITLE:

DATE: 1-24-01 CONSENT CALENDAR YES ☐ NO ☒

- ☐ OUGHT TO PASS
- ☐ OUGHT TO PASS WITH AMENDMENT
- ☒ INEXPEDIENT TO LEGISLATE
- ☐ RE-REFER
- ☐ REFER TO COMMITTEE FOR INTERIM STUDY
  (Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

1-25-01

Per Chairman Batula, Rep. Burnham has withdrawn this minority Report.

Ruth Batula

Vote _____.

Rep. DANIEL BURNHAM
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

Minority Report

HB169FN

THE MINORITY OF THE COMMITTEE BELIEVES REFERRING HB169 IS PREMATURE AND AN UNNECESSARY EFFORT TO SEND A THREATENING SIGNAL TO THE TASK FORCE ON THE CERTIFICATE OF NEED STATUE. THE COMMITTEE HEARD CONVINCING TESTIMONY THAT SUCH ~~HE~~ A SIGNAL IS NOT NECESSARY; INDEED, THAT THE TASK FORCE HAS MOVED AGGRESSIVELY AND FAIRLY TO STUDY THE CERTIFICATE OF NEED LAW.

Dan Burnham

COMMITTEE REPORT

COMMITTEE: **Health, Human Services and Elderly Affairs**

BILL NUMBER: **HB 169 - FN**

TITLE: repealing the certificate of need law.

DATE: November 13, 2001 CONSENT CALENDAR YES ☐ NO ☒

☐ OUGHT TO PASS

☐ OUGHT TO PASS WITH AMENDMENT

☒ INEXPEDIENT TO LEGISLATE

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

Repealing the certificate of need law is not a new issue for the legislature. In fact, there is a task force currently working to examine and study the certificate of need and make recommendations for change. Their recommendations will not be finalized in time for this session. Therefore, a majority of the committee considered it unnecessary to keep this bill active at this time. New legislation will undoubtedly be recommended by the Task Force report.

Vote 15-4.

Rep. Alida Millham
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

Health, Human Services and Elderly Affairs

HB 169 - FN, repealing the certificate of need law. **INEXPEDIENT TO LEGISLATE**

Rep. Alida Millham for Health, Human Services and Elderly Affairs: Repealing the certificate of need law is not a new issue for the legislature. In fact, there is a task force currently working to examine and study the certificate of need and make recommendations for change. Their recommendations will not be finalized in time for this session. Therefore, a majority of the committee considered it unnecessary to keep this bill active at this time. New legislation will undoubtedly be recommended by the Task Force report. **Vote 15-4.**

COMMITTEE REPORT

COMMITTEE: Health, Human Services and Elderly Affairs

BILL NUMBER: HB 169

TITLE: Repealing the Certificate of Need Law

DATE: 11/13/01 CONSENT CALENDAR: YES ☐ NO ☒

☐ OUGHT TO PASS

☐ OUGHT TO PASS W/ AMENDMENT

☒ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ INTERIM STUDY (Available only 2nd year of biennium)

Amendment No. _____

STATEMENT OF INTENT:

Repealing the certificate of need law is not a new issue for the legislature. In fact, there is a Task Force currently working to examine and study certificate of need and make recommendations for change. Their recommendations will not be finalized in time for this session. Therefore, a majority of the committee considered it unnecessary to keep this bill active at this time. New legislation will undoubtedly be recommended by the Task Force report.

COMMITTEE VOTE: _____

- Copy to Committee Bill File
- Use Another Report for Minority Report

RESPECTFULLY SUBMITTED,

Rep. Alida Millham
For the Committee

Rev. 07/30/99