COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
INSURANCE COMMITTEE

PUBLIC HEARING ON HOUSE BILL 305

MAIN CAPITOL, ROOM 140
HARRISBURG, PENNSYLVANIA
WEDNESDAY, SEPTEMBER 3, 2008, 1:00 P.M.

BEFORE: HON. KATHY MANDERINO
HON. RON BUXTON
HON. FLORINDO J. FABRIZIO
HON. NICK KOTIK
HON. SCOTT W. BOYD
HON. ROBERT W. GODSHALL
HON. GLEN R. GRELL
HON. ROBERT MENSCH
HON. MAGUERITE QUINN
HON. BRAD ROAE

ALSO PRESENT

RICK SPEESE, EXECUTIVE DIRECTOR
KATHY MCCORMAC, REPUBLICAN EXECUTIVE DIRECTOR

HEATHER L. ARTZ, RMR, CRR
REPORTER - NOTARY PUBLIC

I N D E X

REPRESENTATIVE MANDERINO: Ladies and gentlemen, we're going to begin the hearing if folks want to get settled. I'm Representative Kathy Manderino. And on behalf of Chairman Tony DeLuca, I welcome you all to this Insurance Committee hearing on House Bill 305.

Before we get started, I just want to mention that Chairman DeLuca's brother had a very serious stroke this morning and he is back home with his family, which is why he is not here. And we keep his brother and their families in our thoughts and prayers.

Before we get started with Representative Mundy's testimony, if the members of the committee want to do introductions, and we can start, Ron, all the way over at your end of the room.

REPRESENTATIVE BUXTON: Ron Buxton, Dauphin County.

REPRESENTATIVE GRELL: Glen Grell, 87th District Cumberland County.

REPRESENTATIVE FABRIZIO: Flo Fabrizio, Erie County.

REPRESENTATIVE KOTIK: Nick Kotik, Allegheny County.

REPRESENTATIVE ROAE: Brad Roae, Crawford

County.

REPRESENTATIVE BOYD: Scott Boyd, Lancaster County.

REPRESENTATIVE MENSCH: Bob Mensch Montgomery County.

REPRESENTATIVE GODSHALL: Bob Godshall, Montgomery County.

MR. SPEESE: Rick Speese, executive director.

REPRESENTATIVE MANDERINO: Thank you. And Representative Mundy, we are ready for your testimony.

REPRESENTATIVE MUNDY: Thank you. Good afternoon, Madam Chairman and members of the committee. I want to thank you for this opportunity to testify on House Bill 305, which re-establishes a Certificate of Need process in Pennsylvania. As you will learn from my testimony, this bill is critical to helping rein in the escalating costs of health care.

Health care inflation is out of control. That is no secret. It's been projected that health care costs will soon consume one-fifth of the U.S. gross domestic product. Every double digit rate increase in premiums causes more Pennsylvanians to lose access to health care, jeopardizing their health, forcing many to forgo cost-effective preventive care, and shifting the burden of health care cost to

government and to those who still afford insurance.

Double digit rate increases have become all too common. According to the Governor's Office of Health Care Reform, health insurance premiums rose 76 percent between 2000 and 2006. While median wages increased by only 13 percent.

A recent survey by Aon consulting worldwide projects that health care costs are expected to rise more than 10 percent into next year.

Pennsylvania, like other states, is struggling to address the issue of affordable health insurance for all its citizens. But our efforts are destined to fail unless we begin to address the major obstacle, out of control health care costs.

There simply is not enough money to insure all Pennsylvanians until we bring health care inflation under control. One of the significant health care cost drivers is unnecessary duplication of expensive medical technology and services.

Pennsylvania's long running Certificate of Need program was allowed to expire in 1996. Since then, there has been no statutory requirement directing health care facilities to justify the purchase of expensive technology or specialized services which are often available in a facility down

the street.

As a result, there has been a dramatic proliferation in the number of highly specialized clinical services, ambulatory surgical centers, and diagnostic imaging centers. There are three imaging centers all within a mile of my home in Kingston, which is not a large municipality.

The statistics are mind boggling. The Department of Health reported that the number of licensed ambulatory surgical centers in the state increased from 44 to over 230 since the expiration of Certificate of Need.

That's an increase of over 400 percent. According to a November 2003 study in Health Affairs Magazine, the number of free-standing; that is, non-hospital, MRI units in Pennsylvania increased 47 percent from '99 to 2001. The same study found that the availability of additional free-standing MRI units is associated with the higher number of outpatient MRIs per person and more total spending. Consider the fact that during that same period, 1999 to 2001, the number of MRI scans increased from 9.3 million to 13.5 million. This 45 percent increase in utilization is estimated to have cost 3.4 billion, according to the Blue Cross Blue Shield Association.

The equipment used to perform MRI, CT, and PET scans is very costly. According to the Pennsylvania Health Care Cost Containment Council, the average MRI machine is about around $2 million to purchase and 800,000 per year to operate. These costs are ultimately passed on to consumers.

In addition, a 2005 Legislative Budget and Finance Committee study reported that since the sunset of CON, health care facilities have established 21 diagnostic cardiac catheterization programs, 31 new cardiac catheterization programs, and 24 open heart surgery programs. The study found that procedure proficiency volumes are recognized indicators of health care quality, especially with regard to specialized clinical services, such as cardiac cath, open heart surgery, and organ transplants. In other words, the more procedures a health care professional performs the better they are at it.

For example, if a community has 300 people who need open heart surgery, and there are three heart hospitals in the area that each perform a hundred of these procedures, it stands to reason that you would have higher costs and poor quality than if one of these hospitals did all 300. Wouldn't it be better both from a cost and quality standpoint if the other

two hospitals performed some other specialized procedure needed in the community?

In his original Prescription for Pennsylvania, Governor Rendell proposed to create by executive order a regional review process similar to CON. The Governor's plan included the appointment of a bipartisan commission to recommend and develop criteria for evaluating capital investments in health care as well as determining regional health care needs. Unfortunately, this initiative has failed to materialize and has since gotten lost in the larger health care debate.

My House Bill 305 seeks to rein in the technological arms race in Pennsylvania by immediately reinstating a process to determine the need for expensive and perhaps duplicative equipment and procedures in a community. House Bill 305 lays out a process whereby any health care facility or health care provider must apply to the Department of Health for a certificate of need in order to initiate or expand services above a certain dollar amount.

House Bill 305 also strengthens the original CON program by adding another -- a number of additions and changes. Key components of the bill include creating local review committees to review certificate

of need applications and make recommendations to the Department of Health. Funding for this would be provided from the patient's safety authority appropriation; requiring applicants to submit a databased cost analysis showing that there's not a more appropriate, less costly or effective alternative of providing the proposed services, and that the proposed service will not have an inappropriate adverse impact on health care expenditures; requiring the Pennsylvania Health Care Cost Containment Council to assist the Department of Health in the application review process; creating a look-back provision to require the Department of Health to monitor the quality of the facility one year after certificate has been issued by requesting data from PHC4, including mortality rates and the number of procedures performed; banning physicians' self-referrals by incorporating portions of Chairman DeLuca's House Bill 1750.

According to Health Help, a radiologist management company, nonradiologist physicians who self-refer order two to eight times as many scans as other doctors. This unnecessary imaging costs our health care system approximately $16 billion per year.

House Bill 305 also sets capital expenditure

limits beyond which a CON would be required. They are as follows: 500,000 for new high cost technology or high cost replacement technology in any health care facility; one million dollars for equipment, other facility improvement for a free-standing facility or office within a hospital, or $2 million for any other hospital-based improvement.

Again, the purpose of House Bill 305 is to reconfigure our health care system by considering community health care needs on a regional basis so that capital expenditures on medical technology can be prioritized for certain areas but limited where the market is already saturated. This proposal changes the conversation from provider profit to provider cooperation.

Doctors and hospitals should work together to create regional centers of excellence where specialists have the room to become experts in specific procedures without trying to be all things to all people.

Opponents of CON will tell you that the duplication of these health care services is about choice and competition. I believe it's about profit. We need to recognize that competition is not always the solution. Sometimes it's the problem. And in

this case, it's driving people who need health insurance out of the marketplace.

What choice does a family without health insurance have? Double digit health care inflation is simply unsustainable. Ever increasing health care costs are damaging our economy and tearing down our standard of living. How can we ever hope to ensure that all Pennsylvanians have access to health care if we do not take the necessary steps to make it affordable?

You can call it certificate of need or something else that sounds more palatable. You can amend the bill to fix what you think needs improving. But this process is a common sense way to rein in health care costs. It's time we rejoin the 36 other states that have such a process in place. The providers are not going to do it. The insurance companies are not going to do it. It's up to us to help those who cannot help themselves against health care inflation.

I thank you for the opportunity to testify and I would be happy to answer any of your questions.

REPRESENTATIVE MANDERINO: Thank you, Representative Mundy. I think my mic is shorting out. Questions from the members? Representative Roae.

REPRESENTATIVE ROAE: Thank you. And thank you Representative Mundy for your presentation. One thing I was wondering, this is good for me as a freshman legislator, I can kind of see both sides of the issue. If you have more people offering the same services, consumers have choice, competition should lower prices. On the other hand, too much duplication increases the cost. So I appreciate your testimony.

One question I do have is has there been a study with the 36 other states that have a Certificate of Need program, what is their inflation rate for health care cost compared to the states who do not have that?

REPRESENTATIVE MUNDY: I don't have an answer to that. I can tell you that there have been numerous legislative Budget and Finance Committee studies done over the years, at least three that I'm aware of. I refer to the latest one in Pennsylvania. I can't speak to what other states are doing or to what other health care cost inflation factors might be at work in those other states that might not be at work here. So I have no comparison state to state.

REPRESENTATIVE ROAE: I think getting those numbers could probably help us a lot as we work through this legislation. And the second question is

how much of the inflation and health care cost do you attribute to a lack of the certificates of need?

REPRESENTATIVE MUNDY: Well, I can cite the statistics that I gave you in my testimony. With regard to dollar values, the 45 percent increase in utilization of MRI facilities, outpatient MRI facilities has resulted in $3.4 billion in additional cost from '99 to 2001. And who knows, you know. There are even more now, so that's kind of an old number. I'm sure it's even far higher now than it was. There's another statistic in here that talks about -- I believe it was --

REPRESENTATIVE ROAE: I guess what I'm interested in --

REPRESENTATIVE MUNDY: There are two statistics in here that talk about -- and I can't find the other one as I look through this. But there are two that give specific dollar values in billions, in the billions, with regard to what we believe is the cost of this proliferation of high tech, very expensive equipment that, again, is often available down the street.

REPRESENTATIVE ROAE: I think it would be helpful to know, you know, if, you know, that 76 percent increase in health insurance premiums from

2000-2006, you know, if 5 percent of it is because of this or 10 percent of it or, you know, 50 percent of it. Because I think that would help, you know, clarify how important this is. And --

REPRESENTATIVE MUNDY: Well, I understand that the PHC4 is currently undergoing this discussion among the members of the PHC4 board, Pennsylvania Health Care Cost Containment Council. And I believe that that would be an appropriate question for them. You know, again, the prolifer -- as you so adequately pointed out in the very beginning, choice is wonderful. But for those who can't afford the choice, because of the higher cost, there's no choice at all. They just die.

So, you know, there is this choice that we have as policymakers about whether we're going to continue to allow the unnecessary and very expensive duplication of this equipment and its services, or we're going to begin to rein it in so that people aren't going to continually lose access to health care.

So I welcome your questions. I look forward to working with all the members of the committee to get the answers to those questions. I can tell you that one statistic I've learned is that 6.5 percent of

your health care insurance premium is because of people without care. So every dollar in unnecessary expense that's added to the system is going to drive more and more people out and shift those costs more and more to the un -- to government and the insured from the uninsured.

REPRESENTATIVE ROAE: All right. Thank you.

REPRESENTATIVE MUNDY: Thank you.

REPRESENTATIVE MANDERINO: Thank you. Representative Mensch.

REPRESENTATIVE MENSCH: Thank you, Madam Chairman. Representative Mundy, good to see you again.

REPRESENTATIVE MUNDY: Good to see you.

REPRESENTATIVE MENSCH: Bright and cheery in yellow. There seems to be a real ying and yang here on this. On the one hand I hear you saying that we have these wonderful services available; but on the other hand. There's a cost factor. I'm just wondering when we limit the availability of the services, and we might make it more affordable, what do we do to the quality of care? And before you answer that, let me preface further.

I had a recent conversation with the chief medical officer of one of the larger insurance

providers. And we were talking about the availability of some of the advanced services in more metropolitan areas, particularly Philadelphia in this case, versus what might be available in Kingston or in a more remote area. I'm not quite familiar with Kingston. You still have an office there.

What he's offering is that information is that the doctors in the more sophisticated medical technology sophisticated areas have the ability to prescribe more of these services. And so the incidents of use increases just because the availability, first. And secondly, they also do it because it is available and they have to ensure that they cover every base because of potential litigation.

How does -- how do you reconcile all of that with let's limit the availability of the technology in the hope that we're going to drive down the cost but at the same time making the service less available, we may be actually penalizing our constituents, not having the availability of the service, and we do have that couple hundred pound gorilla in the form tort reform where the doctors feel they're obligated for their only financial necessity to be able to provide these services.

REPRESENTATIVE MUNDY: Well, let me start

with your last issue first. With the issue with regard to the issue of referring patients for these various diagnostic procedures as an example, many of the physicians who are doing the referring own interest in these facilities. So while many in the medical community might tell you that the reason that they overprescribe testing is because of medical malpractice, I would suggest that common sense would tell you that if you have an ability to make money by referring patients, that it's human nature to do that, when there's any question whatsoever as to whether it's appropriate or not.

And again, when you look at the utilization figures before certificate of need expired and after it expired, you will see that many physicians are using this as a way to make additional income. And so I believe that self-referral should be limited or eliminated completely. And I think that that just is important from a cost perspective and a quality perspective.

And you started out with a question about quality. And I did address that to some extent in my remarks. I remember, was it last year or the year before, when the Department of Health wanted to force cardiac programs throughout the state into a study at

Johns Hopkins University to make sure that this -- these additional facilities that have -- that had been approved were doing quality work. And there was just an uproar among those facilities that they had already invested in these expensive programs and that now they didn't want to have to be reined in or forced to do anything to prove that there was good quality in any of those programs. And that's my characterization of what happened. You can go back and read the journal debate.

But the Department of Health and the -- I'm forgetting the name of the nationwide cardiac physician organization, made it perfectly clear that the more procedures you do the better our -- better you are at it, and that the number of facilities that were performing these procedures without the adequate backup facilities in the area, without as qualified staff because they hadn't performed as many procedures, were putting people at risk. The quality was less. It has to be when you do fewer procedures; you don't do it as often; you don't do it with the same teams. You just don't do as good a job as those -- those facilities that do it every day, day in and day out. They know what some of the risks might be and they're prepared, on-site, at the moment to

deal with whatever comes up. So, you know, I think with regard to quality, this addresses the quality issue.

And with regard to access, you know, you -- Kingston has about 15,000 people in it. The neighboring city of Wilkes-Barre has about 45,000. Now, I just told you in my little area of Kingston there are three MRI facilities and there may even be more within outside of that one mile radius. I didn't count them all. The hospital is across the river a few more blocks away. And I didn't even talk about the MRI facilities in the city of Wilkes-Barre itself. You will -- trust me. You will not have one minute's problem finding an MRI unit in my region.

REPRESENTATIVE MENSCH: But isn't that good?

REPRESENTATIVE MUNDY: Only if you're willing to pay for the 2 million piece of equipment and the 800,000 maintenance for each and every one of those MRI units that is not being fully utilized. No, I don't think in this case that that's a good thing, because it's added to the cost of health care to the extent where people can't afford health care.

REPRESENTATIVE MENSCH: Just two quick follow-up comments slash questions. On the -- on the self-referral where you started, is there empirical

data to suggest that these doctors actually are self-referring and what is the extent of that, and with what -- what consequence does it have on cost contributor is it to the overall problem?

REPRESENTATIVE MUNDY: There is empirical data. In fact, in my notes here, and I'll fish it out and give it to you, the med -- Medicare reimbursement entity that determines rates is looking at the issue of self-referral right now.

REPRESENTATIVE MENSCH: But that quantifies it as abuse which is what you're suggesting. I want to separate it from --

REPRESENTATIVE MUNDY: I am suggesting.

REPRESENTATIVE MENSCH: -- the medical necessity versus abuse, okay. So we're clear on the objective. I'd love to see that data, though. And secondly, and I'll go back to the same reference that you used with Representative Roae, 45 percent increase in utilization is estimated to have cost $3.4 billion. That's a big number, 3.4 billion. Is there any quantification, though, of medical benefit of that increase in utilization has provided?

REPRESENTATIVE MUNDY: I don't think there is. If there is, then I'd love to see it. I'd love -- I'd love to see the opponents of certificate

of need come forward and show me that increasing utilization to that degree has dramatically improved health care quality, because I don't see it. I see continuing escalated cost and continuing lack of access and people being kicked out of insurance programs because they can no longer afford them. And I don't see a commensurate increase in the quality of care.

REPRESENTATIVE MENSCH: I have to join you in your comment and say that I would love to see the data that suggests it has an improvement but I would suggest that just 45 percent utilization costing that in other dollars doesn't necessarily mean it's bad. So -- because we don't know what the -- what the benefit side of that factor might be.

REPRESENTATIVE MUNDY: Well, it certainly seems bad if people can't afford health care.

REPRESENTATIVE MENSCH: Thank you.

REPRESENTATIVE MUNDY: Thank you.

REPRESENTATIVE MANDERINO: Thank you. Representative Boyd.

REPRESENTATIVE BOYD: Thank you, Madam Chairman. Representative, it's good to see you. A couple quick questions for historical context. We had certificate of needs sunsetted in 1996. How long had

we had that in this state as the standard? Do you know?

REPRESENTATIVE MUNDY: A very long time. Mr. Speese, can you give us -- my under -- my staff is telling me since the late '70s.

REPRESENTATIVE BOYD: Okay. And somewhat anecdotally, but that was when I was fully operating my business and I seem to recall the cost of health care and my health insurance premiums being a major issue through the '90s too, with double digit rate increases on a regular basis.

I'm just kind of curious, if you feel, like theoretically then, up until the -- that time that there should have been some pressure to help to keep prices down, but it didn't feel that way as a business owner. Do you have stats that actually show that during that time period that we had certificate of need it actually did help control costs?

REPRESENTATIVE MUNDY: I don't have those statistics with me. I have read those statistics. And my recollection is that we didn't experience double digit inflation in the early '90s. It wasn't until the mid to late '90s that it really began to get out of control.

And let me be clear. I am not suggesting

that this is the only factor in health care costs. Absolutely not. And I've introduced other bills having to do with quality, total quality management programs in exchange for reduced medical malpractice premium as an example. There are other things that we should be doing.

And I'm also not saying that the former certificate of need program was perfect, far from it, and probably needs to be tweaked. But this bill is a beginning of the discussion and we need to gather those statistics in one place and the committee needs to take a look at them. And we need to do more about controlling health care cost before we continue to ask either the private sector or the public sector to keep on paying. That's kind of --

REPRESENTATIVE BOYD: Well, clearly I totally agree with you the spiralling costs is the issue. The question is how do we get at those. And this is certainly an idea that's worth discussing. I wholly commend you for initiating the discussion.

Just out of curiosity sake, as kind of a classic coming out of the classic economic model, theoretically, increased supply should have a net decrease in cost. Supply and demand. You increase the supply so -- I mean, that's one of the classic

arguments as to why you don't need certificate of need. What Representative Mensch said, is it a bad thing that there's an MRI location on everything corner, shouldn't that in a classic economic sense lower costs? Obviously statistics don't bear that out.

Do you have -- can you speculate as to why doesn't a classic economic model operate in the realm of health care?

REPRESENTATIVE MUNDY: Well, I think because there's no incentive on anybody's part to control cost. Physicians and other entities buy and invest in these expensive health care facilities and the equipment in them and the staff and the services provided by them, and they have to pay for that expensive equipment, whether it's used or not.

So you start an MRI unit, you've got $200 million in capital investment plus your $800,000 a year in maintenance, plus your staff and your radiologist and all of that. Those costs have to be covered whether they're fully utilized or not. And they are. And you know, nobody in those facilities is going to be charging less for those services than the guy down the street. And so, you know, competition is not working here, clearly it's not working in health

care. There's no incentive on the part of the patient not to use these facilities. If you have insurance and your doctor refers you to an MRI, you just go. So there's no -- the incentive on the part of the patient.

I'm frankly amazed at the -- and I look forward to hearing HAP's testimony today, because I keep hearing from hospital folks that they -- these ambulatory surgical centers and the diagnostic testing labs and other services that are performed out of hospital are taking away their profit margins and leaving them with the least profitable services to offer and putting so many of our hospitals in dire straits. This is a direct result, in my view, of what we've allowed to happen with the expiration of Certificate of Need. So, I mean, there is no incentive on anybody's part to control costs here. In the end, if you can't afford it you just don't get it.

REPRESENTATIVE BOYD: I appreciate your testimony. And I really appreciate the answer to the questions, because it's one of the other issues that this committee has been taking up in other hearings and we work with throughout the summer, ultimately the issue of PHC4 and having that reauthorized, but also giving them the ability to publish prices, if you

will, costs, either what we were looking at is either the M-Care reimbursement rate, somehow trying to establish a standard as to what a fee should be so that a consumer -- because ultimately we're going to control costs, there's got to be a buy-in from the consumer, the person who's actually utilizing that care. And that's almost exactly what you said.

There's no incentive on the part of the patient to not utilize those services. One of the great incentives is that if at some point they have a buy-in, you know, there's some incentive. It's some -- it's costing them something to get them to start asking questions. Is this service necessary.

And basically I find myself agreeing with you on the premise of self -- of self-referrals. I'm not a big mandate that you can't do it. I don't necessarily want to disincentivize a physician from investing. How do I tell someone they can't invest in another technology or whatever, but at the same time when there's no check and balance from them self-referring, that can be problematic when they're seen as, you know, the expert and then they can say you have to use our other offices. But I wonder if, as we empower consumers to try and make better health care decisions and health insurance decisions, if we

wouldn't get at some of those things.

So I really appreciate the discussion and the way we're attacking this, and kind of multi-facetted, multi-level effect. I agree with you we got to get at cost issue and this is certainly one we need to have in the equation. Thank you, Madam Chairperson.

REPRESENTATIVE MANDERINO: Thank you. And thank you, Representative Mundy, very much for your testimony. We're ready to move on to our next testifier. That's Mark Guenin, M.D., Guenin, I'm sorry.

The green light's on. You're ready to go.

DR. GUENIN: Terrific. Thank you to Representative Mundy for the invitation to speak here. Before I get started, though, I want to make it clear that my remarks will concentrate exclusively on imaging services. That's what I do for a living. I don't claim any expertise on ambulatory surgical centers or specialty hospital shops. We're going to confine the remarks here to discussion of imaging services.

Two years ago I had the somewhat awkward experience of inviting myself to meet with Representative Mundy and tell her that the first 95 percent of her bill that talked about certificate of

needs was rendered irrelevant by the last five percent that talked about self-referral. And that, furthermore, that first 95 percent certificate of need was, in fact, counterproductive as long as you got self-referral under control.

So as you know, that legislative session expired without the bill having gone anywhere, and here we find ourselves two years later having the same discussion only in a more public forum. And I commend your sense of bravery for inviting me to criticize.

But anyway, before we get too far, you ought to know a little bit of background. I am a diagnostic radiologist with Tristan Associates. We have several offices in the greater Harrisburg area. They're all outpatient imaging centers, free standing.

The patient will walk into our office only if another health care provider has asked them to come to us. If that health care provider has a question that they think only can be answered by some sort of imaging study, then they'll send the patient to someplace, and our office being one such place. We will perform the imaging study. I or one of my colleagues will render an interpretation, get that interpretation back to that health care provider, and then care will go on from there at the control of that

health care provider.

I do not control any aspect of that patient's care except for that limited portion when they're on -- when they're on my property.

I am not in a decision making position. Nobody calls me their doctor and comes in every year for a checkup. The only way I have to keep patients coming to my office is to provide a good service, to treat that patient with respect and courtesy and compassion, to perform that imaging study with state-of-the-art equipment, to render an accurate interpretation, and to get that interpretation to my referring physician or health care provider in a timely fashion so that that can make a meaningful contribution to that person's decision making.

And if I fall down on any of those steps, well, I can pretty easily expect my business, if you will, to taper off and people aren't going to be coming to my office anymore.

That really is the only way that I have to stay in business. The idea that if you build it they will come doesn't work under that model, nor should it. Our facility will float or sink only on the quality of our care. By contrast, somebody who is a self-refer, has a steady stream of patients coming

into their office for treatment and other purposes and can -- and has the ability to steer the patients to their own wholly-owned facility, that insures a steady stream of patients going through their $2 million scanner with their two technologists and chillers and shielding and all that sort of thing. That is a real meaningful cost.

The possibility for abuse there should be obvious to anybody who thinks about it. Not only do I not have the opportunity to increase patient flow other than by providing good services, it's specifically forbidden, CMS transmittal 1725 available on request.

But in addition, you can imagine if Dr. Smith were to send a patient, a series of patients to my office and all the sudden found that extra tests were being ordered right and left. Well, you can imagine they would pretty quickly send them to one of my competitors. And that's exactly as it should be.

The adverse effects of self-referral are quite obvious. The cost we've talked about. The increase in cost of medicine are certainly greater than inflation, and a component of that is increase in the cost of imaging.

Now, the increase in the cost of imaging has

outpaced the rest of the average of medical costs. Some component of that is due to our aging population. Obviously, 65 year old requires more medical care of all sorts than a 25 year old. Some component of that is due to better technology. Answer Representative Mensch's question, when was the last time you heard of somebody going in for exploratory surgery? That's something you hear on old movies these days. CT scans have largely done away with that.

Certainly in a trauma setting where the patient is crashing before your eyes then they go on to have exploratory surgery, but above and beyond that, advanced technology has rendered that moot.

So you can look at the cost of imaging, and unless you're willing to also look at the decreased number of exploratory operations, you haven't answered that question.

Cost is just one thing, though. Any x-ray study, any CT scan, any nuclear medicine scan results in exposure to ionizing radiation, so any inappropriate usage of that equipment will expose the population to more radiation. Some of the tests have injection of contrast which have their own adverse reactions and so forth. The list goes on.

In fact, self-referral is anticompetitive.

Imagine you're a patient in that doctor's office and being sent down the hall to their scanner. Most patients aren't going to sit there and say, well, you know, I sort of like Tristan Associates, could you maybe send me to them? Most patients are not going to have the backbone to stand up to their doctor and say that. Furthermore, if that doctor has an insured steady stream of patients coming through that scanner paying off the $2 million loan and paying off the $800,000 a year cost, what incentive does that doctor have to upgrade their equipment, to do the latest software upgrade, to swap out scanners when the technology is new. You can keep these scanners running for 15 years. But the real life span, a 15 year old scanner just isn't cutting it these days. The image quality is not up to state of the art. So it's possible to get these things limping through for much longer than you would, but you'd be protected from the other competitive pressures if you're a self-referrer.

There are many myths that are often floated in defense of self-referral. The convenience issue is a very common one. Well, it's just more convenient for Mrs. Smith to have her scan right down the hall. But that doesn't really hold any water. It's very

easy to look at a claim submissions and spot the date of the office visit and the date of the imaging study. And in less than 3 percent of the time that's the same day. In other words, that patient had to come back even to their self-referrer's office. And if you don't do the scan on the same day, that's not convenient. The convenience issue is a smoke screen.

There is ample evidence of overuse, to answer your question. The studies have -- were out as early as early 1990s that up to two to eight times overuse of overimaging services were done, performed by those who had the financial incentive to do so. Those studies have just accumulated since that time.

There are strong arm tactics that come into play. I've alluded to patient trying to stand up to her doctor and saying, well, I really need to have a choice and not being given that, which surprising in all this is the third-party payers. They ought to have an extremely strong incentive to put some curbs on this. And so far they've either been silent or taking baby steps. In honesty, they'll privately tell you that, well, we're all aware of the problem and we'd love to solve it but nobody wants to be the first one to take the step because it's not easy to see what would happen if an insurance company said, well, you

can't self-refer, then those patients would go into the doctor and the doctor would say, well, I love to keep seeing you but your insurance company won't let me. What they won't tell you is that they won't let me scan you, but they'll just say they won't let me. And so that patient will go back to their employer and say, you know, the insurance company that you chose for me isn't letting me see my own doctor anymore, and that employer's going to go back to the insurance company and say your rules have prevented my employees from seeing the doctor of their choice and we're going to shop elsewhere. So that explains much of the silence on the issue.

You put some restraint on that particular bad practice and the whole certificate of need incentive goes away.

If I open up an imaging study and stock it with a state-of-the-art MRI, CT, and ultrasound and nobody shows up and that folds, that comes out of my wallet. That does not have any adverse effect on the taxpayer. The taxpayer does not spend one dollar to bail me out of a bad business decision. The idea that that cost gets passed on to the customer only holds true if you introduce self-referral into the equation. If self-referral isn't in the equation, my bad

business decision doesn't cost any of you one dollar.

So in that light, why I should have to go to a committee of laypeople and others who don't know anything about imaging and try and talk them into justifying my purchase of a scanner for our Carlisle office makes no sense. My father-in-law, who's a retired owner of a business, never had to come before a state committee to decide whether he needed to buy a new delivery truck or not. His failure would not have cost you any money either. So why the rules are different when I don't have the ability to pass any cost along to the customer or to the taxpayer is not clear to me.

Above and beyond that, the Federal Department of Justice and Federal Trade Commission back in July of 2004 came out with a report, "Improving Health Care: A Dose of Competition." And among their many points, they address specifically certificates of need. And they state, it states, With certificate -- Certificate of Need programs should reconsider whether these programs best serve their citizen's health care needs. The agency, the DOJ and FTC, believe that 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; market income -- and use UCN procedures to forestall competitors from entering the market.

I mean, superficially I should love CONs. Our group does not have any plans in the near future for installing a new scanner, opening up an office. So we're pretty fat, dumb, and happy here. And so we should love CONs because that would prevent any competitors from entering our market. I don't. I grizzle at the notion that I have to come to the state for permission to open up a new scanner.

Anyway, I've probably overshot my time limit. So in summary, the certificate of need program is not an answer. If you put meaningful limits on self-referral, the whole need or the whole purpose of the certificate of need program disappears and I encourage you to explore those lines further. Thank you.

REPRESENTATIVE MANDERINO: Thank you very much. And did I pronounce it right, Dr. Guenin?

DR. GUENIN: Guenin, that's right.

REPRESENTATIVE MANDERINO: Representative Mensch.

REPRESENTATIVE MENSCH: Doctor, good afternoon. Let me understand. Your opening comments

or your opening set of thoughts were that competition is working in the industry and it really relates to quality of care, that is the primary factor within the competition?

DR. GUENIN: Sure. We have competitors right in this city and, you know, they're in a similar situation to us. And they can't steer business their way; we can't steer business our way, but we each have friendly competition. Our competition costs nobody anything except if we make a boneheaded business decision then we -- we eat that. But, sure. The ability to say we have a 64 slice CT scanner has meaning. The ability to say we have an open MRI that can accommodate claustrophobic or obese patients or pediatric patients, that has meaning. And that is real and genuine. That is a benefit of competition.

REPRESENTATIVE MENSCH: And then the self-referral is the one Kathy added to that, that it is taking away from the competitive aspect of we had controls over the self-referral, your feeling is the certificate of need may not be necessary.

DR. GUENIN: That is exactly right.

REPRESENTATIVE MENSCH: Last comment, but you make an interesting observation that because of the aging population in Pennsylvania, we do have a third

oldest population and perhaps that is contributing to the increased use or the increase of utilization of the sophisticated technology.

DR. GUENIN: Sure, that's right.

REPRESENTATIVE MENSCH: Thank you very much, Doctor.

REPRESENTATIVE MANDERINO: Thank you. I have a few questions, Doctor. I was in the legislature when CON expired. And actually prior to its just expiring there was actually a legislative proposal to repeal it, so there were legislative hearings and discussions about it in depth, not just kind of letting it go away.

And I want to respectfully challenge one of the points that seemed to be the crux of your testimony, because I remember a very different dialogue 12 years ago. And that is when you said that this has no impact on the taxpayer and our competition costs -- doesn't cost anybody anything. And what I remember from the discussion back when we were operating under CON was in particular most of the more expensive medical technology was concentrated in hospital settings as well as -- and then most of the more expensive medical procedures were concentrated in the teaching hospitals of -- kind of in the hospital

world. And the issue really became one of not just the volume and expertise issue when it came to medical procedures that Representative Mundy talked about, but the -- in the whole health care delivery system and what made a hospital run or work were areas that I would call the cost maker and areas that were the cost losers.

And what was happening was that as more and more cost maker services got spun out of the hospitals into free standing and ambulatory settings, kind of cherry picking out the profit centers away from the hospitals, we left all of our hospitals with the cost losers. And so, therefore, we duplicated services in a way that made it more difficult for hospitals to stay in business and provide a critical needed service because we left them with all of the things that lose them money and allowed all of the things that were kind of helping their balance sheet spin out.

Now, you obviously don't have that view, but that's the bias I'm coming from. So I'll give you a chance to convince me that my bias is unfounded. But I think that that, from where I sit, as a taxpayer as well as a health system, concern that we as policymakers have to keep into account.

DR. GUENIN: Well, under any CON the folks

that are entrenched are going to have the microphone. You are going to have hospital systems that will come and testify that the CON is necessary, we need to continue it because they don't want competition. Quite honestly, nothing that we've done is anything that a hospital couldn't do on its own. None of the outpatient imaging centers that we've established are beyond the means or the -- you know, the will of the hospital.

If they wanted to set up an ambulatory or an outpatient imaging center, they could have done so. Quite easily. They declined. And in many instances -- and so I'm not sure if you are expecting somebody from the suburbs to have to drive in to the city for a scan, you know, the market preference is quite clear. They would like to have it at a place close to where their doctor is, where they live or they work and so forth. So central planning efforts have historically failed and that was one of them.

REPRESENTATIVE MANDERINO: Was your diagnostic radiology center, I forgot what you said the name of it was, established pre or post expiration of Certificate of Need?

DR. GUENIN: We were around long before CONs sunset.

REPRESENTATIVE MANDERINO: So when you set up your -- your, whoever owns it -- it was done within the current context of -- or within the current at that time context of Pennsylvania Certificate of Need program.

DR. GUENIN: Historical, sure, we did plain films, mammo, ultrasound, that was about all you could do because you can't get a CON for MR, you couldn't get a CON for a CT. Actually you could. There was -- I don't want to say gray markets, perfectly legal transactions out there to buy and sell CONs. That alone should tell you how meaningless that particular program was. If you could pay money for a CON, they were going for $40,000 at the time to buy yourself a certificate of need.

REPRESENTATIVE MANDERINO: Where were you buying the certificate of need from?

DR. GUENIN: I don't know. That was before I was cognizant of those dealings. But we didn't. They were there.

REPRESENTATIVE MANDERINO: Thank you. Representative Mundy.

REPRESENTATIVE MUNDY: Hello, Dr. Guenin.

DR. GUENIN: Hello, again.

REPRESENTATIVE MUNDY: Thank you again for

coming to testify. As I listen to the testimony, though, it did seem to me that you were, with regard to the fact that you don't think certificate of need is worthwhile, it seemed to be strictly within the purview of the diagnostic imaging and the self-referral. And so I guess I would like to ask you if you were to take MRI, CT scans, PET scans, all of the things that you're currently doing out of the CON mix, just as an example, how would you deal with the -- okay, so we just do self-referral, we take that away. How would you then deal with the proliferation of ambulatory surgical centers and other cardiac cath units, you know, all of these other things that I'm talking about with regard to CON, apart and aside from what you're doing. You know, I can understand your point about self-referral within a radiology setting. But how about the hospital setting or the ambulatory surgical center?

DR. GUENIN: Well, as I pointed out initially, that's not my area of expertise, so I'm not, you know, I'll be happy to give you my personal opinion, but that shouldn't matter anymore than anybody else's here.

REPRESENTATIVE MUNDY: So we -- so when we listen to your testimony, we simply need to understand

that you are strictly talking about CON in the context.

DR. GUENIN: Of imaging.

REPRESENTATIVE MUNDY: Imaging.

DR. GUENIN: Um-hum, indeed.

REPRESENTATIVE MUNDY: Thank you.

REPRESENTATIVE MANDERINO: Thank you very much. We appreciate very much your time coming and your testimony today.

Next on the agenda we have James Yates, M.D., board member, and Robert Puglisi is board member PA Ambulatory Surgery Association. And, gentlemen, I'll leave it up to you who goes in which order. You just have to make sure the green light is on and you're ready to speak into the mic.

DR. YATES: Good afternoon. Members of the insurance -- House Insurance Committee, I'm here today on behalf of the members of the Pennsylvania Ambulatory Surgery Association to express our opposition to House Bill 305. My comments will be brief and succinct, but to the point.

I'm Dr. James Yates. I've been actively practicing board certified plastic surgeon from Camp Hill, Pennsylvania. I've been in practice for over 40 years. I am the medical director of the Grandview

Surgery and Laser Center, which I assisted in developing as one of Central Pennsylvania's first free-standing multi-specialty surgery centers in 1985.

In addition, I have my own state approved and Medicare certified office based ambulatory surgery center known as the Vista Surgery Center. I am chief of plastic and aesthetic surgery at Holy Spirit Hospital, also in Camp Hill. Lastly, I am the immediate past president for the American Association for the Accreditation of Ambulatory Surgery Facilities which accredits over 1200 ambulatory surgery centers across the country.

I am a member of the Pennsylvania State Medical Society's patient safety committee and also serve on the safety committees of the two national plastic surgery organizations, the ASPS and the ASAPS.

As a surgeon, my main focus and concern has always been and should always be patient safety and quality. CON rules relate to need and not quality and safety per se. I have recently been a contributing author to an article in a national plastic surgery journal where 1.4 million ambulatory surgery center cases performed in ASCs were analyzed and the overall complication rate was found to be 0.42 percent, one-third of that -- of similar cases performed in

hospitals.

This is proven patient safety. Beyond this significant factor, patient safety, but directly related is quality. Outpatient ambulatory surgery center surgery can and does provide the patient with, one, improved advances in medical technology; two, greater choices in scheduling since the operating rooms are not affected by emergency cases; three, more convenience to the patient.

A study performed over nine years ago indicated that a surgical procedure to be done at a hospital as an outpatient required 44.2 hours of additional preoperative scheduling and preparation than when the similar case was performed at a free-standing ambulatory surgery center.

Patient privacy and confidentiality is clearly more effective and possible in an ASC. The ASC facility has a demonstrated reduced between case, so-called, turnover time, lending to more efficiency in the facility. The patient in an ambulatory surgery center has less exposure to *nosocomial infections and particularly MRSA, methicillin resistant staphylococcus aureus, again, demonstrated by numerous studies. Nursing studies have indicated that patients treated in ambulatory surgery centers have less

emotional distress and sustained more of a family feel based on post-discharge questionnaires.

All the above can be received at lower costs, as you'll hear from my colleague. I should also add that ASC quality and safety are highly regulated, wherein 85 percent are Medicare certified and 43 states require their licensure.

There are numerous studies which also demonstrate that the increased number of procedures performed do not, and I underline that, do not and cannot act as a measure of safety or quality. Finally, it should be noted that the requirements of the presence of all necessary equipment for patient safety and resuscitation are exactly the same as those required by law for hospitals, and all ASCs are required by Pennsylvania state law to provide the same recorded data on patient complications, death, or infections as are hospitals.

I thank you for giving me the opportunity to speak with you today. And I will be available to answer questions that you may have. Thank you.

MR. PUGLISI: Good afternoon, ladies and gentlemen of the committee. Thank you for inviting me here today. My name is Robert Puglisi. I'm opposed to House Bill 305. A little bit about me first.

I am the regional administrator and CEO for Huntingdon Valley Surgery Center in Huntingdon Valley, Pennsylvania. I have an undergraduate degree from Albright College in Reading, an MBA in Health and Medical Services Administration in Widener University in Chester. Prior to running the surgery center, I've worked for one of Philadelphia's largest acute care hospitals, I provided consultation services on the financial and productivity standpoint for numerous hospital systems and hospitals in eastern Pennsylvania, as well as over 400 physician practices. I've worked for Independence Blue Cross, and I'm a member of both the Pennsylvania and Montgomery County Medical Societies. In addition, and the reason I'm here today is I hold a government board position with the Pennsylvania Ambulatory Surgery Association, PASA.

REPRESENTATIVE GODSHALL: Could you speak into the microphone, please?

MR. PUGLISI: Sure. PASA is a grass roots effort started here in Pennsylvania that brings all the ambulatory surgery centers together to share information, disseminate -- enact a vehicle of communication for our industry with legislators. It's our newest venue. Prior to this it has grown from being more of a clinic, purely clinical aspect.

House Bill 305 poses to reintroduce the Certificate of Need in the State of Pennsylvania. Myself and the organization I represent oppose this bill for the following reasons. It will hinder the development of new health care facilities. 2004 a report from the Federal Trade Commission determined that the state should decrease barriers to the entry into provider markets. States with Certificate of Need program should reconsider whether these programs best serve their citizens' health care needs. The agencies believed that on the balance CON programs are not successful in containing health care costs and that they pose serious anticompetitive risks that usually outweigh the purported economic benefits.

Two, CONs reduce access to the delivery of health care. By definition, Certificate of Need programs create barriers to the entry and expansion of health care services in the marketplace. Legislative and regulatory barriers that are created in a free market economy with little or no justification create an atmosphere of any competitive behavior by reducing competition and maintaining or increasing existing prices for services rendered.

Three, they prohibit the expansion of health care facilities by increasing costs and bringing new

venture to the market. The CON program will require the establishment of state review board and local review committee composed of the affected groups. The committees require funding for their administrative cost. The Pennsylvania Department of Health responsibilities will need to be expanded to include development of new standards review and approval and the denial process. Data will need to be obtained and analyzed and reported on from other organizations which are involved with the delivery and oversight of the health care. Violators of the bill will require the due process of law to adjudicate, levy fines, and to punish and to enforce penalties.

Fourth, artificially prohibiting competition in the marketplace, by legislatively thwarting or delaying the increased competition would in other venues raise antitrust concerns. Perceived objections to applications for review and approval discourage applicants prior to their concepts being tested in the free market economy. Mark Botti, chief of litigation section of the Department of Justice's Antitrust Division, stated, "Competitors have used the CON process to allocate health care services between themselves - an ostensible violation of antitrust laws." He has gone on to say that territorial market

allocations by cartels, preventing competitive entry into markets, have allocated -- have allowed CON -- have -- have been allowed under the CON regulatory programs.

The opportunity cost is number five, lost revenues and increase new jobs in the state of Pennsylvania. The CON program will restrict those entering the marketplace, thus reducing additional taxable revenues for for-profit ambulatory surgery centers, as well as the elimination and the creation of new jobs within the Commonwealth.

And finally, the denial of physician referral to the facilities where identified surgeons have a financial interest, this portion of the bill will prohibit the development and opportunity of ambulatory surgery centers within the state. ASCs have the ability to deliver cost effective health care with the same high standards of hospital based facilities. ASCs are the for-profit entities that require the referrals of physician investors. They are also revenue producers and job creators for the state.

I wanted to share with you some of my daily and personal experiences in surgery center market. Huntingdon Valley Surgery Center is a four operating room, two procedure room facility. It's in its fifth

year of operation. We employee over 30 people on a full and part-time basis via signed contracts, with over 60 vendors to provide ancillary services. These are everything from mom-and-pop operations like an ice vendor to multi-national corporations such as Cardinal Health.

In 2007 the center completed over 6100 procedures within the following specialties: We offer colon/rectal surgery, gastroenterology, general surgery, Ob/Gyn, ophthalmology, orthopedics, pain management, and podiatry. This surgery center is one of over 235 ASCs in the state.

Most recently -- I want to speak to you about access to care. I know that legislation's been mentioned a lot today. One of my surgery owners of my center called, had a 24-year-old male who was an uninsured roofer in his office during office hours. He had no insurance. The surgeon called and wanted to schedule a shoulder arthroscopy. Within 5 minutes we had the surgery scheduled. We offered the next-day service. The bill was the problem. If he had gone to the hospital he would have received full charges. We were able to work out Medicare reimbursement level for that paid level for that patient, would not be unduly burden.

So, you know, that's an excellent demonstration of immediate access to care at an inexpensive rate. The date of service that was convenient for the patient and the physician. I could tell you had that gotten to the hospital, not only would the patient have been charged full charges, it would have also been to-follow case. To-follow it means it would follow the entire day of scheduled surgery in the hospital and then at the end of the day after an emergent case was put on then the patient could have surgery. That could have been as late as 9:00 at night. At our institution we would have done by and sent out by 4:00 that afternoon.

Surgeons with the best vested interest in the financial and facilities home are more in tuned with related costs to providing health care and the cost to those that require the health care. As an owner, they have increased awareness of the pricing and administration of health care and frequently choose non-name brand medical supplies as opposed to name brand in order to save costs. Surgeons are more willing and requiring -- require to negotiate with vendors for better pricing on products, a true hands-on approach to decision making and economic discipline.

Patients with serious and long-term illnesses will benefit from traditional hospital care. There's no question about that. However, hospitals offer a broad spectrum of care and support services in day-to-day operations. Day-to-day health care maintenance items such as colonoscopies, shoulder arthroscopies, pain injections, can be done much more efficiently and quicker in ambulatory surgery centers and much more cost conscious about delivering those. We are contract -- 70 percent of my business is contract with one of the largest payors in southeastern Pennsylvania. I have a contracted rate that guarantees me no more than X dollars per procedure. I have to live on that margin. It's not a free for all throughout where I can charge whatever I want and get whatever I want. 70 percent of my business is contracted with managed care.

In free market economy where cost is no object and equitable reimbursements exits, ambulatory surgery center should not exist. However, economy's in medicine have created alternative of surgery centers. Over the last 15 years surgeons' incomes have dropped. In order to stay in parody with other economic forces, increased medical malpractice insurance costs and technology investments, they need

additional source of income.

At your convenience, I invite you, if you're ever in Huntingdon Valley area, visit my center. I'd be more than happy to give you a tour, help you understand the economics of how it goes and the realm of what is allowed by HIPAA. Thank you for the opportunity to meet with you. And I will answer any questions you have to the best of my ability.

REPRESENTATIVE MANDERINO: This mic doesn't like me. Thank you both very much. We do have a couple members with questions. Representative Mundy.

REPRESENTATIVE MUNDY: Thank you, Madam Chairman. Mr. Puglisi, I'm glad that your Huntingdon Valley surgery center isn't too far away from Wilkes-Barre. I'll be referring my constituents who want a reduced rate to your facility from now on. And Mr. Puglisi, you referred -- Puglisi?

MR. PUGLISI: Puglisi, correct.

REPRESENTATIVE MUNDY: You refer to a study and it was referred to one other time. Could we get a copy of that? Who did that study?

MR. PUGLISI: I'll shuffle the paperwork and I'll get that for you. Was there another question I can answer while I'm digging this out for you?

REPRESENTATIVE MUNDY: Actually, my other

questions are for Dr. Yates.

MR. PUGLISI: I'm sorry? Oh, for Dr. Yates.

REPRESENTATIVE MUNDY: Well, perhaps you could look for it and share it with the committee chairman.

MR. PUGLISI: Yes, I can get that for you.

REPRESENTATIVE MUNDY: Thank you. Dr. Yates, I'm aware that the cardiologists have volume standards with regard to quality. And from what I took from your testimony, it almost sounds like plastic surgeons don't have any such standards; is that correct?

DR. YATES: As I indicated, volume of cases does not verify safety or quality.

REPRESENTATIVE MUNDY: That's not my question. My understanding is that to be board certified in cardiology you have to perform so many procedures per year and that is considered a high quality standard for those physicians, those surgeons. Is there no such standard for your specialty?

DR. YATES: No. That's not true. Before you become board certified, that --

REPRESENTATIVE MUNDY: I'm asking --

DR. YATES: That's not correct. The board certification you have to produce so many cases of various types before you become board certified. And

then you have to present to the examining board any number of these cases and also complications therein before you become board certified. And then there is a rule that every seven years you must be recertified and produce numbers of cases that you have performed.

REPRESENTATIVE MUNDY: So there is a standard of volume with regard to being board certified and staying board certified?

DR. YATES: Yes, there is.

REPRESENTATIVE MUNDY: That was my question. And that is my point when I talk about quality. So am I incorrect in saying that the more procedures you do the better you are at it?

DR. YATES: No.

REPRESENTATIVE MUNDY: I am not correct in staying that?

DR. YATES: That is correct.

REPRESENTATIVE MUNDY: So if I do one procedure a year and another physician does 500 procedures a year, that one physician is -- it could be just as good at doing that procedure as the one who does 500 a year?

DR. YATES: That is correct.

REPRESENTATIVE MUNDY: Okay. Thank you. And my last question. I apologize for being long. This

is a question for both of you. To what do you attribute the annual double digit health care cost inflation and what do you believe are the solutions for us as policymakers to rein those in?

DR. YATES: I can answer briefly. Example, our medical executive committee meeting for our surgery center met last evening. And we do an analysis of what the average facility cost is per patient regardless of whether it's orthopedics; general surgery; ear, nose and throat, whatever. That facility fee average for any patient is $354. That cost for the same procedure at the nearby hospital is $1625. That's where the cost come in.

REPRESENTATIVE MUNDY: I'm not getting -- I'm not getting your point.

MR. PUGLISI: I can speak, last year the federal government needed to reduce Medicare spending. Ambulatory surgery center reimbursement rates are set at 65 percent of what's called a HOD rate, hospital outpatient department rate. I'm only reimbursed 65 percent of what a hospital would get for the identical procedure. So to say that an ASC is guilty of double digit inflation by itself is not true.

REPRESENTATIVE MUNDY: That, by the way -- I'm going to stop you right there because that's not

what I said.

MR. PUGLISI: You asked about what do I consider attributable to --

REPRESENTATIVE MUNDY: To what do you attribute, and I'm talking general terms here, I'm not talking about specifically about any one aspect of health care. I'm saying there's double digit rate increases in health insurance. I want to know what you believe are the reasons for that and what you believe are the solutions to that.

MR. PUGLISI: I believe the reasons are not -- there is no one reason. The insurance companies, the health insurance company's not really a health insurance company. It's a finance company. They don't make a billion dollars a year profit for no reason. They need to be looked at. The entire spectrum of care needs to be looked at.

You know, should an ASC exist? I'll be honest with you. An ASC should not exist. Hospitals should have done a much better needs of serving the needs of their physician constituents, of the staff that employ them, of the patients they have. So a better model was created and it's what you have now.

Not every hospital should exist. I come from the, you know, from Philadelphia where, you know, in

some sections of the city there's a bar on every other corner and a hospital on every other corner. The City of Philadelphia is overbedded. It's been overbedded as long as my career, which is very short compared to yours in this industry and I know that. Not -- things need to die on the vine and the fat needs to be cut out from all levels of the spectrum of health care. There is not one level that would solve this problem.

REPRESENTATIVE MUNDY: I totally agree with you. Do you have any comment, Dr. Yates?

DR. YATES: No. I totally agree with what Robert has said. I just want to give you anecdotally the situation where rules that say that you refer to your own facility and save money.

A patient comes to me with a cancerous lesion. His insurance will not cover him at the hospital because of the size of the lesion. They will not cover him at the ambulatory surgery center, so I said I'll do it in my office surgery center. The time took me 35 minutes to do the procedure. The bill for the procedure was sent to the insurance company. The insurance company does not pay me a facility fee. The total fee for the incision was $452. I received a check for $27.32. But I didn't ask him to pay the difference. That's where self-referral sometimes does

help.

REPRESENTATIVE MUNDY: Thank you.

REPRESENTATIVE MANDERINO: Thank you. Representative Mensch.

REPRESENTATIVE MENSCH: Gentlemen, thank you. Both of you used the term convenience in your testimonies. And Dr. Guenin also talked about convenience. Convenience to me can also mean availability of the service. Convenience sometimes connotes an overavailability. I'm not sure that's what we're trying to connote here, but that is my question. Is it convenient or is it available? In other words, if available is a hundred percent of the service that we need, are we past a hundred percent? Or does convenient in this case mean available?

MR. PUGLISI: I would say that in some areas of the State of Pennsylvania we are probably -- it's probably overconvenient, overavailable. In other parts of the State of Pennsylvania it's probably just the right amount of utilization. No entry into the marketplace existed before free-standing ambulatory surgery center, which is the only one I'll speak to, was opened where there was none. It's a benefit for that community.

REPRESENTATIVE MENSCH: So back to your

comments then just a moment ago about leaving things to die on the vine that were maybe overbedded and so forth, would that overadequacy be in the same area as where you might envision things should be allowed to die on the vine?

MR. PUGLISI: Yes.

REPRESENTATIVE MENSCH: Okay. And they're probably more metropolitan areas.

MR. PUGLISI: I would think, yeah. But there's also a higher concentration of population that require more services and higher concentration of physicians and it would allow the physicians in that area to subspecialize into unique things that are maybe not served in the greater communities. You know, it's got to balanced out.

REPRESENTATIVE MENSCH: The whole thrust where I want to go with this question then is availability and how it relates to your constituents, your patients. There is an expectation within the population, if the government didn't create it, health care didn't create it, people by themselves didn't create it, it's something we've grown accustomed to and that is that we have health care available when we need it. Do CONs increase that availability and comfort those people with that expectation or does it

decrease that expectation?

DR. YATES: It certainly decreases it. The availability isn't as much. There aren't as many surgery centers, there aren't as many office based surgical facilities where you can go. And again, I use the 44.2 hour thing. And that was unbelievable thing way back when. People just could not at a hospital get as much taken care of in the amount of time that it took. You can drop 44.2 hours out of your day getting procedure, a procedure done in a hospital, but now the convenience is you can get it done within the next day at a surgery center and possibly sometimes the same day.

REPRESENTATIVE MENSCH: And these services are competitive; is that correct? Your opinion? Competitive?

DR. YATES: Yes, they are.

MR. PUGLISI: Many times the same surgeon providing it at the hospital and by the surgery center. It's just a matter of where they can get it scheduled faster or cheaper.

DR. YATES: And if I may add, in our area, we are noticing that some of the -- because there is competition, some of the outpatient surgery centers are lowering their -- their facility fee rates because

they want to be in competition with the others. We're finding that all the time. And we have the first ambulatory surgery center in Central Pennsylvania here way back in 1985.

And anecdotally, maybe I shouldn't waste your time, but I will give you anecdote because I think it is important. I was in this same room back in 1983 because I had to try to fight against the fact that CON law was in existence to try to develop the ambulatory surgery center known as Grandview. And I was opposed by four area hospitals. Each one of those opposed me. I won the certificate of need award, but it was then taken by a lawsuit to the state Supreme Court. And at the State Supreme Court I won the case after $176,000 of expenses to a very good attorney. And the day that I won it and the *Patriot News* wrote in the paper that I had won the case, I heard from four hospitals asking me if they could partner with me in this facility.

REPRESENTATIVE MENSCH: So we're a quarter of a century later you're still thriving, you're --

DR. YATES: Yes.

REPRESENTATIVE MENSCH: -- prosperous?

DR. YATES: Yes.

REPRESENTATIVE MENSCH: Had there not been a

CON process then you would have established and you'd still have the same relationship with the hospitals?

DR. YATES: I'm sure we would. But the hospital that fought me the hardest came in and said let me partner with you. And they're now a joint venture with me and we're working very well.

REPRESENTATIVE MENSCH: As Representative Boyd pointed out, too, there would be one less cheaper -- or one less rich attorney. Thank you.

DR. YATES: That's correct.

REPRESENTATIVE MANDERINO: Representative Boyd. No attorney jokes.

REPRESENTATIVE BOYD: You knew I had to get one in. I'm kind of curious on, I'm not sure which page of your testimony, but you talk about the self-referral situation. You've actually referenced it. You see it as a positive, and both of you have indicated that. I got mixed emotions. So I'm going to put you on the spot.

Do you believe that there are physicians out there that abuse self-referral, that they actually refer people to their facilities that they have an interest in in a fashion that helps facilitate their bottom line?

MR. PUGLISI: No more than exists in other

entities and other disciplines that abuse them. I could speak to personal experience during my consulting time. I always knew I was getting close to a touchy topic with a surgeon or a physician when they became very argumentative, combative to some extent, and stopped returning my calls, that they were doing something that was probably untoward or immoral or unethical. It certainly exists in medicine. I know it exists in other industries. It exists in religion. So, yes.

DR. YATES: I totally agree with that comment.

REPRESENTATIVE BOYD: So it does exist. How do we deal with that issue in an environment, and again I'm going to go back to this, where the patient, the ultimate payer, really is not empowered to make those decisions?

MR. PUGLISI: This is a very difficult subject. I'm as close as I can get to medicine without being, obviously, educated as a physician or a nurse. I'm more savvy than 90 percent of my friends who are nonphysicians or nurses. And if my physician, my internist says to me you need a CT scan to determine what's going on, I'm going to trust my judgment in him and my faith in him that he's making

the right decision. He may or may not have a vested interest in where he's going. Certainly it is in -- the Department of Health requires that we make that statement available to patients that the physician may be referring you to an institution which they have a vested interest. Certainly my documents for registration on day of registration state that fact. When asked, I have no problem providing that information.

DR. YATES: In addition, I'll add to that comment that I deal with Quality Insights, which is a peer review type group. And I also work for various insurance companies reviewing cases in which they feel maybe there have been overuse, misuse of the particular procedures and of a number of procedures are being done which they think are a little more than should be, I review those cases. So in essence the insurance companies will see that you are doing an awful lot of cases that you may not need to have done and you have to have definite positive characteristics from the patients history and physical that this needed to be done. So there are some overseers besides just the facility.

REPRESENTATIVE BOYD: When a self-referral is done, when somebody would say to me, Scott, you need

to go get such and such a procedure, an MRI, and there's a disclosure that's affiliated facility, whenever I had situations, not necessarily the affiliated facility, but when I've had situations and I've asked what's that procedure cost, you know, I've never, ever gotten an answer.

What does an MRI cost? I heard anywhere from a surgical procedure that it was reimbursed at $27 to shoulder surgery that it was $435 to a procedure done in a hospital that was $1600.

My point is is how do we expect to deal with this issue when there's no disclosure to the customer, the consumer? You know, the real payer of this is not Capital Blue Cross. I don't care that they negotiate a rate behind closed doors that I have no access to. And I try and get those contracts and I can't get them. And my friend sitting over here from Capital. I'm not picking on Capital. I can't get from Highmark and I can't get it from IBC. I can't get it from Sam Marshal. How am I supposed to make wise decisions if I don't have access to what you charge for your procedures?

I have a published fee schedule that I'm required to provide. You'll notice the testimony that I've provided you, we're with AAAHC, which is a

national organization. I have to have a fee schedule available to provide to any person who asks what something is -- what we charge, if I can do that. Not to be elusive to your question, but there is what I charge, what I receive as a contracted rate from one of the payers, there's also when you get an EOB which we've all seen is there that's allowed amount. That amount, allowed amount and what I am contracting are two totally different numbers. And generally that number's two or three times higher than what I get. Then there's the actual cost of what it costs me to do a procedure. I can tell you, you know, just off of the top of my head, a colonoscopy with no removal of a polyp in the intestine will cost me about $315 to do. And I'll make about $463 on that. And from that, I need to, you know, that's just the cost interoperative. It doesn't include the nurses' costs, you know, pre and post op and any kind of supplies that I use. That's what the operating room, the overhead, things like that.

That numbers -- I can arrive at that number if you ask me that number directly. I am understand -- my contract with my largest payor, actually all my payors, precludes me from speaking to anyone else in my organization including through

passive organization of what I'm reimbursed on a procedure.

They would be your best source of what they may pay each facility. Allegedly it's by geographical zip code and need and population within that zip code. They may not give it to you, but that would be the best source. They've got the fingers into all of our health care lives, you know, mine, yours, what you've used. You know, slice and dice, that information by zip code, by street, by city. You know, it's incumbent upon the legislature of Pennsylvania to help us with that, even help me as a private consumer is to have them open their databases to you and say, you know, this is what it costs in Huntingdon Valley to do it. This is what it costs in Philadelphia five miles away. This is what it costs in Wilkes-Barre to do that procedure. I would think that the Philadelphia cost is probably more expensive out of those three scenarios and that probably Wilkes-Barre is the cheapest. I can give you my number but it's irrelevant in a large context.

REPRESENTATIVE BOYD: It seems to me at some point as a part of this whole discussion with certificate of need is real cost transparency, not just published charge rates that have no relationship

to what's actually paid for or agreed to from services rendered. And it seems until we somehow empower the patients, the consumers who are actually the ones paying for the services that we're going to continue this circular argument and never get to ultimately what I believe Representative Mundy was trying to get at in the beginning and that's the overall cost factor. So appreciate your testimony.

REPRESENTATIVE MANDERINO: Thank you, Representative Boyd. And thank you, gentlemen, for being here today -- oh, I'm sorry. Hang on. Representative Roae.

REPRESENTATIVE ROAE: I'm sorry. I hadn't asked to be recognized earlier but I do have a quick question. When you look at ambulatory surgery centers, what percentage of your business comes from programs that's paid for by the state, things like medical assistance, CHIP, adultBasic, things like that? Is the amount of patients that you see comparable to what hospitals have, or are more of your customers paying with insurance they receive through their employment?

MR. PUGLISI: First you have to remember that ambulatory surgery center does not have patients in and of itself. Patients are all from the physicians

who are either affiliated with it or an owner in it. Huntingdon Valley's very affluent neighborhood, okay. In and of itself it doesn't have a large Medicaid/CHIPs type population that we serve, so consequently I do not see that much. If I were located in a different neighborhood that might be different. My physicians just don't see it. Therefore, we don't treat it.

I do have one anecdotal, I can give you some information. He's seen -- he seems to have a large percent of average people who are kind of itinerant in the neighborhood and they are cash paid patients. So we work out Medicare rates for them. You know, but that's nominal at best, you know, maybe five or six patients a year at that rate. That's just the neighborhood that I serve.

DR. YATES: The original CON rule that I recall required that if you accepted -- if you were given the certificate of need you were required to do at least 10 percent of your cases in the ambulatory surgery certainty were supposed to be medical assistance-type cases. Reviewing our past one or two years in our surgery center, it's 13 percent of cases.

REPRESENTATIVE ROAE: How does that compare to the regular hospitals in your geographic area as

far as the percentage of medical assistance that they have?

DR. YATES: Again, I will agree with what Robert said is that it is locale related. The hospital across the street, which is of course in Camp Hill in a high per capita area, has very few Medicaid and medical assistance cases. I suspect that Pinnacle Health System downtown Harrisburg has quite a few more. So it's hard to really get a general statement. But I will say that certainly our surgery center does as much, if not more, perhaps, than what the hospital across the street does.

REPRESENTATIVE ROAE: Some of the hospital administrators I've talked with, you know, they're concerned that regular hospitals get stuck with all the medical assistance business and some of the other centers take the better paying customers, people that have insurance through work, you know, the Medicare business, things like that, and the hospitals are stuck with the Medicaid, you know, adult -- state programs that don't pay as well. Is that accurate do you think, or is that just a perception?

DR. YATES: I agree, again, with what Robert said. If the person comes to my office that's Medicaid, I will put them wherever it's open, most

convenient to do, whether it's hospital or the surgery center. And if they find the date and time location is more convenient at the surgery center, that's where they'll go. I have no relationship to what the insurance was. And if they won't cover it there I'll do it in my office.

MR. PUGLISI: Frequently when a patient is scheduled at our center it's not the physician necessarily that makes that choice. You know, he sends it to a scheduler, says here's Mrs. Jones, she needs something, schedule it. And they are out of it at that point. Yes, it's probably -- yes, it's got to be in the back of their mind, it would be ludicrous to think that it wasn't, but the surgery center scheduler gets to talk to the patient. What day do you want to come, how soon do you want to have it done? I can offer here or here, where do you want to go?

So it's not as decisive, well, this is Goldman, I'm sending over here, I'll put the crap over there. That's not true. And certainly during the economic of it, I've got a surgeon that's got five cases on and let's say they're all out of network or contracted payers, one's going to be a low payer. It really makes no difference at that point to put that patient on. You know, because I've got my cost for

the day covered. They can come in and do them and it's not a problem. And we should do that. It's good -- you know, it's good human, as good citizens we should help our fellow people and leave them better than we found them. I certainly have no compunction not to serve them.

REPRESENTATIVE ROAE: All right. Thank you, gentlemen.

REPRESENTATIVE MANDERINO: Thank you very much for being here today. Next on our agenda we have Dr. Lund, president Pennsylvania Medical Society. Welcome.

DR. LUND: Thank you. Thank you for having me. It was interesting. I'm a little wound up because this morning, coincidentally, I'm an actively practicing urologist and I practice in Erie, Pennsylvania. And I had a cancer case this morning that could have been done at a surgery center or in the hospital, but because of the limited availability, I have to do it in the hospital. And unfortunately I got bumped by an hour because of an appendectomy, which is sort of the process that can occur. And I made my 300 miles down here in record time. So I'm a little wound up. But thank you very much for having me.

Well, good afternoon. I'm, as you heard, I'm Dr. Peter Lund, president of the Pennsylvania Medical Society based here in Harrisburg. And let me begin by thanking the committee for hosting the hearings today. We appreciate -- the society appreciates the opportunity to testify. We're here to discuss various aspects of House Bill 305, which including the Certificate of Need and the prohibition on referrals. But before I get in to these issues, I want to say that I don't envy any of you at this panel today because it is a two-edged sword.

Not long ago my colleague, Dr. Bruce MacLeod, testified on behalf of the Pennsylvania Medical Society in front of another Pennsylvania House of Representatives committee on various health care issues, and CON was discussed at that time.

At one point in time, Pennsylvania did have a CON. And before it was dropped in the '90s everyone was complaining that it wasn't working. Essentially, it was a rationing -- it was rationing care and decreasing access and it was a process that put legislators like yourself in a position of having to choose one local entity over another in a race to secure CON. And as an aside, I was involved in one of those races and which one hospital won and one

hospital lost.

Today we have an opposite situation. Some people are concerned about the increased utilization of health care services as a lack -- because of a lack of a CON and how this will impact the overall health care costs.

This is a great dilemma, and as I said before is a double-edged sword that I can appreciate the difficult position that this bill has put you in.

Pennsylvanians want convenient access to care. But they're concerned about related costs. Ultimately, as a result of the House Bill 305, members of this committee have been told either pick patient access or allowing -- by allowing free markets to do their jobs or picking reduced costs by limiting the amount we provide.

I contend there is a third option. We can find a way to make things work so that House Bill 305 doesn't go against the public's desire to have access to care but manages expenses. The Pennsylvania Medical Society does not support going back in time and reliving the problems associated with CON. And the way 305 is written today, it reminds us much of the unsuccessful past of CON.

We should learn from history. Furthermore,

according to Mark Botti, chief litigation section of the U.S. Department of Justice's Antitrust Division, CO law -- CO laws, CON laws, posed -- in a quote, he said, "Poses substantial threat to the proper performance of health care markets." In his testimony given by Botti in front of the CON special committee in the State House of Representatives of the General Assembly of the State of Georgia in 2007, the Department of Justice claims that CON will undercut the consumer's choice, weaken markets -- weaken markets' ability to contain health care cost and stifle innovation.

An exact quote from Mr. Botti's testimony sums up everything in a nutshell. And he says, They, CON laws, do not provide an economic justification for depriving consumers the benefits of free markets.

I highly recommend that this committee review Mr. Botti's testimony, because it's very important and very pertinent. It also comes from solid research conducted by a staff of Ph.D.s. If you do not have a copy of this testimony, we will be happy to share you -- share a copy with you.

The Pennsylvania Medical Society does believe there are things that can be done to add -- to address unnecessary utilization. For example, we believe that

the marketplace is looking at services specifically to a service area. Large health insurance companies, such as Highmark and Independent Blue Cross, are using clinical qualifications and prior authorizations to limit unnecessary utilization. Specialty societies have developed appropriateness criteria. And that was mentioned earlier by the cardiologists have developed significant appropriateness criteria to securing proper utilization of services in their field of expertise. And that goes across many different specialties.

As long as utilization standards have the input of the medical practice community, this entire debate ends and House Bill 305 is unnecessary. Therefore, health insurance policies can address quality and access while managing cost. Equally important, it lessens the cookie cutter approach that has been used in the past to prevent the old scenarios that permit existing facilities to prevent or limit competition.

Under the old CON, existing facilities could prevent a newer, better facility from meeting the needs threshold. Plus, money also bought some approvals. In either case, neither was satisfactory. 305 also attempts to prohibit self-referrals by health

care providers. On the surface, this sounds logical, to avoid the question related to ethics and kickbacks. But like CON, it's a double-edged sword. And once again, I don't envy any of you at this table.

On the surface this -- this portion of the House Bill 305 attempts to demonize providers, painting them only as interested in making money, and those who attempt to demonize providers on this issue with broad strokes and making outrageous statements to make all providers appear less interested in care and more interested in making a buck. But that's where the double-edged sword comes to play. Patients who have been just diagnosed with a condition find greater comfort in knowing that their doctor can schedule immediate treatment without sending the patient scrambling to another facility, sometimes miles away. Patients also find greater comfort knowing their current doctor will be following them through the necessary procedures.

Imagine a scenar -- imagine the following scenario. A patient enters their physician's office with a specific complaint related to their health. The physician examines the patient, determines that the patient is in need of services that could be provided through a surgery center in which the

physician has a financial stake. If 305 were in place, the patient would not be allowed to utilize the surgery center. Instead, the patient would need to schedule this procedure at another location which may mean switching doctors. This adds unnecessary stress to the patient. It simply delays patient treatment while driving up patient inconvenience and possible costs, even more of a double-edged sword in communities where the patient's only option would be to travel for care. And that's a considerable amount of Pennsylvania.

Why shouldn't patients in these communities be allowed to access care within their communities? We should not discriminate against these patients. Again, the Pennsylvania Medical Society understands the intent of this part of House Bill 305. There can be suspected providers making -- or taking advantage of the situation; however, why punish the patients of Pennsylvania? This would be unfair to the overwhelming majority of physicians who have their patients' best interest at heart. It would be unfair to the millions of patients who are inconvenienced due to geography.

I'll conclude by restating that I don't envy any of your positions in this committee in

relationship to House Bill 305. It's truly the double-edged sword, because ultimately it comes down to access. It is almost political suicide if you take a stance directly on one side or the other, either access or costs. But remember who I work for and you work for is the patients of Pennsylvania. The patients of Pennsylvania want timely and quality health care, and we should be there to provide it.

Thank you very much.

REPRESENTATIVE MANDERINO: Thank you, Dr. Lund. And thank you for rushing down here. We very much appreciate it. Before I turn to members for questions, I would just like to request that a copy of the testimony of Mark Botti, if you guys -- if the Medical Society does have that then you could get a copy of that to the committee? I would like to read it. I'm sure other members would, too.

DR. LUND: We will get it to you.

REPRESENTATIVE MANDERINO: Questions? Mr. Representative Mensch.

REPRESENTATIVE MENSCH: Just very briefly, you sat through the testimony that we've had here and there's been comments on self-referral. Your testimony doesn't address that specifically. So let me ask your feelings on self-referral and its

contributing to excessive costs.

DR. LUND: I'll give you a good example of it. And the example is an orthopedic patient who is 17, 18 years of age has a lesion on the knee that he felt. He went into his physician in Erie, Pennsylvania, to get examined and, unfortunately, the indication which especially has criteria for doing MRIs couldn't be done in Erie in a timely fashion because they had to wait a period of time to get in. It just isn't availability. And partly because there are a whole series of restrictive issues to building their own imaging center in Pennsylvania, especially in western Pennsylvania that are based on certain criteria by insurance companies in the state.

And so as a consequence, what did he do? He's very wealthy family. They flew down to West Virginia, the hallmark of great health care, and they got their MRI, seen by a physician all in one day.

So if we want to develop a second class process in this whole issue, there's a typical example of how the effectiveness of self-referral can be very good for that patient because that patient found out that he didn't have an osteoblastoma of his knee, that he had a benign lesion of the knee and he could go on and play football, which he really wanted to do.

REPRESENTATIVE MENSCH: One other quick question. If you boil down the issue very simply, you're saying manage expenses, that's the third option that we have. It reminds me of an old prof friend of mine said the most concept -- the most competent approach is exactly one constant and one variable. Here E equals MC squared.

Here you've taken it to just manage expenses. How do we get our arms around that? That seems to be the biggest issue that we have. And Representative Boyd spoke about it in earlier question. We don't have rates published, we don't understand all the cost structure. How do we get our arms around that? It's so simple to fix. It seems like it's really a complex issue to understand.

DR. LUND: Well, we're attacking it from multiple different directions, but restricting access and rationing care is probably not what we want to do. But we're looking at it in terms of evidence based medicine, when should certain things be done, and that's been being developed by every specialty. And I would only say that, you know, terms of how the boards work, part of board certification is not only understanding how to do something, but when to do something and when is it appropriate to do something.

And that's all within the context of understanding that. And there are white papers in every specialty that come forward on that. The insurance industry has been using those white papers to try to determine, because they realized that utilization is up. And utilization is basically because we've taken some of the people out of the loop.

I would also tell you that in terms of transparency of costs, if we go ahead and reenact PAC4, which was trying to do some transparency of costs and certain -- in certain processes, you'll have better access. And Pennsylvania was a leader in that. Mine we were -- I was at a meeting in Washington and PHC4 was cited as one of the major inroads in terms of developing transparency in health care. And Pennsylvania was a leader in it. I love hearing that, being a Pennsylvania physician.

So as a consequence, I think that there are several things. We have to develop the transparency issue. I think we can reenact some of our processes that we had in the past. Look at utilization processes that go on. And then finally, the big gorilla is defining what basic health care is, and because that's part of utilization there, too.

REPRESENTATIVE MENSCH: And it goes to that

expectation that we talked about before.

DR. LUND: Yes.

REPRESENTATIVE MENSCH: Thank you, Dr. Lund.

REPRESENTATIVE MANDERINO: Representative Mundy also has a question.

REPRESENTATIVE MUNDY: Thank you, Dr. Lund, for your testimony. I'm not the least bit surprised that the medical society opposes certificate of need. And I'm also not the least bit surprised that you characterize the bill as restricting access and rationing care. You know, when you're trying to sell your position you come up with the most inflammatory language you can think of, and you did a pretty good job. As I hope I did on my end.

I would dispute the fact that we're trying to restrict access here. I believe, as has been stated earlier, that we have a glut of facilities in some places and not enough in others. And the whole point of a Certificate of Need process is to determine where the need exists. If there is a need, certificate of need should be issued. If there is no need, if there is no restriction of access, there should -- you know, there should not -- or there should be -- certificate of need should be denied. So -- and rationing care, we ration care now. If you can afford it you get it.

If you can't afford it you don't get it. That's rationing in every sense of the word. So, you know, restricting access, rationing care, I truly dispute that that's what this bill does.

And with regard to your statement about kickbacks, I want to know why the medical and hospital communities, if that is going on, why that wasn't sent to the Department of Justice or the Attorney General, why that wasn't investigated and stopped in its tracks. But all these years later to come forward with these allegations that you could buy a certificate of need for $40,000, who were you getting $40,000 to and why were there kickbacks allowed and why weren't they prosecuted? Why weren't they investigated? I am completely baffled as to how that can go on and everybody seems to know about it in the medical community and nobody comes forward to make a case for it.

DR. LUND: Well, in terms of addressing the whole concept of where -- where we would have inappropriate surgery center, let's say, or imaging center, it really comes down to who makes the decision, how that decision makes -- gets made. And in an all wonderful world, I think right sizing makes a lot of sense. But at the -- when we have a world

that doesn't work and we have a population that is migratory in many ways and changing in many ways, what ten minutes from now -- like the weather in Erie, you know. You don't like the weather now, wait ten minutes. It changes. So can the population. The needs can change and, therefore, what kind of scenarios do we have there. I think the whole concept of need is a fluid one where the market has a much better way of deciding that need than other ways.

REPRESENTATIVE MUNDY: Well, that's what's happening now when we've got double digit health care inflation that the American people simply cannot sustain. So I look forward to the medical society's suggestions, recommendations about if this is not the proper approach. All I see from your testimony is that the insurance companies should be able to do something with overutilization.

DR. LUND: No. Actually, what I wanted to make sure that the insurance companies are actually using the data from medical specialties to be able to look at how the appropriateness, because frankly, the one thing that medicine doesn't want to do is allow for, you know, the people to be taken advantage of the system, because it hurts -- I don't have any ownership in anything, other than my practice. But I -- but at

the same time, it would hurt all the other doctors out there if there was someone gobbling up a major portion of the pie. We don't want that in terms of financial issues. And frankly, it doesn't help the patients and it doesn't help our profession. So in essence, we look at how utilization is used. We're taking that as a major part of the education of physicians in the future and, frankly, in the recent past.

REPRESENTATIVE MUNDY: Well, and I can certainly understand that utilization, best practice with regard to physicians is appropriate. But, frankly, I'm not sure that I feel comfortable having the payor, the health insurance companies decide what is proper utilization.

I would rather leave that to my physician to decide whether I need a procedure or not, unless that same physician has a personal financial interest in my using the procedure or using the service as opposed to not having any interest in that. And quite frankly, I've never heard a physician say before that they appreciate insurance company telling them that they have improperly utilized a particular procedure for a patient. Everything I hear from physicians in my community is that they feel that they should be the ones to decide what's appropriate or not. And that's

also what I would like to believe and have faith in is that my physician is doing what he thinks is best for me, free from the financial incentive.

DR. LUND: And I would agree with that. I would agree that we don't want to have the insurers solely deciding that. Just like I don't want to have Medicare, which is doing value based medicine now, solely deciding that. But as a consequence, organized medicine, the AMA, Pennsylvania Medical Society and other physicians, other specialty societies have stepped up to the plate to make sure that we do have value in the appropriate degree of -- medical therapies that are out there and that they're utilized appropriately.

REPRESENTATIVE MUNDY: Well, I thank you for your testimony. Again, I look forward to the suggestions from the medical society about how to rein in cost so that people continue to have health care.

DR. LUND: You're welcome. Thank you.

REPRESENTATIVE MANDERINO: Thank you very much. And thank you very much again, Dr. Lund.

Paula Bussard, senior vice president policy and regulation services for the Hospital and Health Systems Association of Pennsylvania. Welcome.

MS. BUSSARD: Thank you, Representative

Manderino and members of the committee. I am Paula Bussard, senior vice president for policy and regulatory services with the Hospital and Health System Association of Pennsylvania. And as you know, we represent the more than 250 acute and specialty care hospitals across the Commonwealth, as well as the patients they serve. And I'm happy to be here today to present the views the hospitals and health systems on certificate of need.

I will produce a little background. I started my career in health care as a health systems planner and a certificate of need reviewer before going out and working in a hospital and then coming to HAP.

First and foremost, Pennsylvania hospital and health systems are committed to accountability and transparency. And we believe that needs to exist both on the delivery of care for the quality and safety of care as well as in the financing of care.

And so this afternoon I want to touch on the perspective of the health care delivery system, our views on certificate of need, and some other issues that we believe are very appropriate regarding accountability for health care.

There are 255 licensed hospitals in

Pennsylvania. In Pennsylvania, in the absence of a certificate of need program, while in other states there have been rapid growth of limited service for profit and sometimes physician owned specialty hospitals, there have only been a few such facilities established in Pennsylvania. Our licensure standards in Pennsylvania are fairly strong in that vein.

Pennsylvania hospitals and health systems have worked to ensure appropriate utilization. Over the last ten years the number of general acute care hospitals have declined by almost 20 percent, while our length of stay has declined by only 11 percent.

You have heard other speakers note on the growth of free-standing ambulatory surgery centers which numbered 48 at the end of certificate of need and now number over 205 such centers. I will note, though, that that rapid growth was not in the initial years following the demise of certificate of need but has been actually more recent years and probably driven as some of the speakers have said, by reimbursement and other financial issues.

I will also note that data from the Pennsylvania Health Care Cost Containment Council shows that free-standing ambulatory surgery centers tend to treat patients that are insured and that are

less complicated than the patients that we treat in the hospitals. They also provide far less care to medical assistance patients and uninsured patients.

Regarding the hospital communities' position on certificate of need, we too oppose reinstituting certificate of need. There is no evidence to demonstrate that a certificate of need program reduces or contains cost for hospitals seeking to establish new services or update their services.

There really are no existing evidence based standards by which any entity could evaluate the need of projects to determine whether that community requires those services. We believe licensure is a more appropriate role for the state in setting standards, including whether there are issues related to quality of care by volume. There are those issues with some types of services, with others there are not. And data from the Pennsylvania Health Care Cost Containment Council clearly showed with cardiac surgery that volume wasn't always necessarily correlated with quality.

We also believe that reinstating an administratively cumbersome and costly process will result in unintended consequences. No one applies for a certificate of need in an area that is -- has a very

low income population or no one applies for certificate of needs for obstetrics or burn, those kind of services that are needed.

Instead of reinstituting certificate of need, we do believe that the legislature should focus on updating the Health Care Facilities Licensure Act and broadening it so that the oversight of health care facilities reflects where health care is being delivered. This would include establishing standards for limited service providers or establishing licensure for imaging centers to assure that Pennsylvanians have access to essential care.

There are other issues related to accountability beyond touching on certificate of need that I wanted to mention. We believe very strongly that accountability exists both on the delivery system side as well as the financing side. Our state has done a lot regarding the transparency of health care by establishing the Pennsylvania Health Care Cost Containment Council. It's done a lot in regarding safety by establishing the Pennsylvania Patient Safety Authority that requires reporting by hospitals and ambulatory surgery centers. And the legislation on health care associated infections strengthens the infection control requirements not only for hospitals,

but also for ambulatory surgery centers and nursing homes.

But we need to improve the transparency on the financing side, as many of the representatives have mentioned.

My testimony includes some data from national studies regarding limited service providers to just support that there are different types of providers serving different types of populations. That lends, in our belief, to the need to have equitable standards. So facilities providing same or similar services need to adhere to the same quality standard, the same reporting standards. And there needs to address the equity issue of serving those individuals without resources or those individuals supported by state programs.

We feel that the state does have a compelling public policy interest in licensure as means of assuring access to quality and safety. But we do believe that we need that certificate of need to kind of create that balance that you've heard other speakers addressing between market forces, consumer demand, access, convenience, and obviously the affordability and quality. We don't believe the state's certificate of need program did that in the

past and it is very hard to achieve that.

I've touched on public reporting. We think it's important. We support reauthorization of the Pennsylvania Health Care Cost Containment Council with amendments that were in the bill that did not get final action before the summer adjournment, because we believe that reporting should be done and it should be updated to reflect reporting to the public based on how the public's getting health care now.

We also have called on the Pennsylvania Insurance Department to establish clear and consistent reporting requirements by health insurers so people can compare apples to apples or oranges to oranges.

We appreciate that both House Bill 305 and House Bill 1750 approach the complex issue of physician self-referral. Giving the changing nature of health care delivery, we would suggest that blanket prohibitions will not likely be able to address the variety of investment, employment, and financial arrangements, but there do need to be clear standards so that the clinical interest of patients is always first and foremost.

And my testimony includes some of the safeguards that we believe that should be discussed with the medical community in establishing those clear

standards for self-referral.

I would also note that reimbursement practices, particularly by Medicare, can have significant impacts on the delivery of care. For example, Medicare's payment for outpatient and ambulatory surgeries has enabled more of the procedures to be reimbursed by Medicare in free-standing or community centers. And that has probably had more of an impact on the growth of ambulatory surgery centers than did the demise of certificate of need.

I'd also note that other reimbursements can affect delivery system access. Increased liability costs for obstetrics coupled with inadequate reimbursement for these services, particularly by Medicaid, have led to difficulties in hospitals recruiting and retaining obstetricians and, subsequently, we have seen the number of hospitals offering obstetrics services decline.

In summary, hospitals and health systems are committed to demonstrating that we provide access to quality and safe care. We view that updating the act by which the Department of Health provides licensure is important for ensuring patient protection, for setting evidence based standards that are consistently

applied regardless of the ownership of a facility, regardless of the setting of the facility, so that quality care is provided in an efficient manner.

I have outlined our general reasons for why we think reinstituting certificate of need will not achieve the objectives that you say that it may. And I'm happy to present our views this afternoon and more than welcome to answer questions.

REPRESENTATIVE MANDERINO: You're not getting off that easy because I have a question, since no one else does. Thank you, first, very much for your testimony. Whenever any of us in the political arena talk about health care, inevitably and usually within the same sentence you hear all of these words, access, quality, and affordability.

Representative Mundy's bill was clearly directed at the affordability issue and at least my understanding of her perception is that if we don't control costs, that we're not going to have access and we're not going to have quality because we're not going to have a health system or we're not going to have people who can afford a health system.

Having said that, it seems like a lot of the suggestions, and you just happened to be the last on the list, of saying CON won't work and what we propose

might work or what we think ought to be addressed instead always seem to me to at least to be going more towards the questions of access and quality, which cost impacts but nobody's really going directly to cost.

In your list, and I don't mean to mischaracterize it so correct me, but when I looked at the whole list of suggestions I thought, well, I guess we can put transparency in the category of things to go directly to the cost or affordability issue because if it's transparent, if we can't see the numbers -- if we can see the numbers at least we know we can address it. But really, if I can just focus you, and maybe it's just how I heard it, of the list of things that you say needs to be improved, which ones do you think are going to make the biggest dent on the cost control end of things?

MS. BUSSARD: Well, you know, first cost is a little more complex than a lot of people look at because you have the cost of health insurance, of which hospitals are a part, but not necessarily the sole driver of why -- well, and they aren't the sole driver of increased premiums. And then you have health care costs broadly, which includes nursing home care, which includes pharmaceuticals, it includes

out-of-pocket individual decisions to get care or buy other products. And so when you look at what's needed to address cost, there isn't any one thing.

What we say about certificate of need is it didn't reduce cost. It really, in some cases in terms of capital expenditures, increased cost because of the length of time it took to achieve a certificate of need. And I would dispute, having worked in Pennsylvania in a health system's agency and certificate of need, I am not aware in the 20 years of Pennsylvania's Certificate of Need program of any selling of certificate of needs.

I think what we all realized was how political that process became, that when you did not get that certificate, you hired contract lobbyists to work with political process.

But we have to face a lot of realities. And this state is doing that in terms of some of the programs we've already initiated. We have an aging population. We know that people with chronic conditions use more health care. And so by coordinating their care, getting your arms around that aspect, we need to look at the life-style issues around our children and obesity and diet and smoking, which this state has also taken major steps on.

So it isn't any magic bullet to address health care. And what we see is looking at aligning the centers such as the Department of Public Welfare or other payors, or even Medicare is trying to do that. And when you align what hospitals pay per episode with doctors who are paid per case, looking at quality, not paying for unnecessary care, it takes all of those things. But I will tell you when you look at national studies around what's driving premium increases, the single largest factor at almost 30 percent is general inflation that the whole nation faces.

And so you have to look at it and try that whole package, which we're doing. You expanded scope of practice. I mean, think about all the steps you've taken. And then look and see, okay, where else are the problems.

REPRESENTATIVE MANDERINO: One last question, if I can put you on the spot a little bit. My recollection is back in the mid '90s when the discussion of the elimination of CON was going on HAP was against the elimination of CON. Now, I realize lots of things change over the course of years, so I'm not necessarily explaining the difference, but I also remember Representative Mundy in her opening testimony

saying, assuming her facts were correct, which I have no reason to doubt, that 36 other states still have some form of certificate of need. So there obviously was a perceived need or perceived concern that HAP had in mind 12 years ago and there's obviously a perceived role or concern that 36 other states have -- still have a concern about.

So what is the essence of that? And if the old CON isn't the answer, what's the issue that you perceive that does need to be addressed with regard to over -- the impact of overaccess or excess access and as a cost driver?

MS. BUSSARD: A couple things. First, 36 states do have CON, but most of those states it's focused on long-term care, not on hospital care.

And yes, in 1996 we supported continuation of Certificate of Need. We were calling, though, for a lot of changes around level playing field and equity. And we believe, and our members over time, that that can be more appropriately addressed by licensure.

If you look at Pennsylvania versus another large state, we don't have, for instance, the limited service hospitals. We have a handful, whereas Texas and some of the other large states have lots of those absent certificate of need. Why is it in

Pennsylvania? It's reimbursement and it's our licensure. When certificate of need went away, we did strengthen ambulatory surgery center requirements and subsequently you've strengthened them again with reporting.

So we don't believe it should be reinstituted because we don't think it will achieve that cost. All it does is set a franchise. And no one is going to seek franchises in the areas of state where -- where health care needs are the greatest. That is your community hospitals. And we have seen a decline, you know. When I started at HAP 20 years ago, there were 225 somewhat general acute care hospitals. We're now down below 170, with utilization at hospitals very high.

So there is cost increases that you need to address, but we think a lot of that lies more around looking at payment and aligning incentives for payment. Because that in the end, in the mid 1990s when certificate of need went away and we did end up seeing restrained costs, it was change in reimbursement. It was movement to managed care. So those are more appropriate ways. We do, though, believe we need to establish clear standards of self-referral so that they're clear, consistent.

REPRESENTATIVE MANDERINO: I thank you. Thank you very much for your testimony. And last but certainly not least, Barbara Holland, Governor's Counsel of Health Care Reform.

MS. HOLLAND: Thank you, Representative Manderino and members of the committee, for permitting me to appear before you and offer some additional testimony from the Office of Health Care Reform. By way of additional background, I just should let you all know that in my youth I actually worked in Washington at the federal level, was deputy bureau director of the Bureau of Health Planning in what's now Health and Human Services, which operate and oversaw the Certificate of Need program. So I'm actually quite familiar with this from the federal standpoint.

As a general matter, I just want to make clear that while the Governor did not incorporate a recommendation for certificate of need in his prescription for Pennsylvania, our office certainly supports the concept of constraining health care costs in this area. And in particular I think, Representative Manderino, you raised some very good points in that this particular piece of legislation really is an effort to focus on one way costs are

driven forward, which is through investment in capital expenditures, overinvestment in some cases, investment which drives up utilization that's not necessary, and lack of investment in certain other areas where needed. So there does need to be, in our view, some kind of process going forward for addressing these problems.

I'll just briefly run through some of the highlights of the testimony. I'm sure you've heard that we are now in the United States exceeding $2.1 trillion on health care expenditures, which is roughly $7,000 per American. That's for 2006.

We now spend 3 -- $5.3 billion a day more on health care than we do on food. And certainly many of the international statistics show that there really is not a correlation between per capita expenditures on health care and health status. If you look at western developed countries across the world, the United States is actually falling in the -- in its health status indicators as compared to other western countries, even though we spend more than just about -- per capita than just about any other country in the world.

This is reflected in Pennsylvania statistics. Between 1999 and 2004 while wages have remained pretty

flat and the economy has increased, the increase in health care expenditures has also increased in a disproportionate way. Per capita medical spending in the state is projected to almost double between 2005 and 2014.

As most of you know from the testimony and from your own background in this area, certainly some of these cost increases are directly correlated to the significant increases in expenditures on new technology, on new procedures that are highly labor intensive and equipment intensive, and resulting in new capital expenditures. And with reference to something that Ms. Bussard said, yes, inflation is one of the largest cost drivers, but the reason that the medical care cost index is higher from an inflation standpoint than the consumer price index is because these expenses for new equipment, new procedures, new technologies, new facilities have to be taken into account when determining the inflation in the medical care cost index.

Some of these new technologies are beneficial. You know, just from my own background, I'm aware that the gamma knife procedure -- a gamma knife is this nonintrusive radiological piece of equipment that costs, I don't know, $5 million per --

per knife, and it's housed in a lead room that in itself costs another 5 or 10 million to construct. It's a hugely expensive piece of equipment, but allows physicians by using radioactive cobalt through very small holes in this big helmet to deal with certain brain tumors and other anomalies that is in a nonsurgical manner. I don't think anyone would dispute that this is an incredible advance in medical technology that provides a way of dealing with these problems in a nonintrusive way. The patient can have these procedures done on an outpatient basis without knives, without surgery. It's really a tremendous move. But the problem is, every hospital has to compete for patients, and they compete for patients by competing for the top docs. And the top docs all want the best equipment and most expensive equipment. And now in Philadelphia, whereas five years ago we had one or two of these gamma knives, I think there are four now currently in Philadelphia and another one across the river at Coopers.

The question is whether all of these very expensive pieces of equipment are needed. And I think that is the issue that's raised by this piece of legislation.

And if it is not, if these are not needed,

how do we best go forward in addressing the problem to control the proliferation of this kind of expensive equipment of technology.

You know, some people refer to this as the medical arms race, which I'm sure you've heard before. There's also, you know, proliferation of, as Ms. Bussard mentioned, of outpatient facilities, outpatient surgical facilities, imaging centers, that has really taken off, partly because of the reimbursement structure, partly because they aren't licensed at the present time. Ambulatory surgery centers are but imaging centers are not.

Surgery facilities grew to roughly -- from roughly 40 in the state when CON sunset in '96 to actually the current year registration is 253 ambulatory surgery centers. So again, the proliferation of these has been tremendous. And with the proliferation has grown more use. You know, if you're going to buy an expensive piece of imaging equipment as a group of doctors, you're going to want to use it so that you can pay it off, because you're carrying either a lease or some kind of loan on that piece of equipment that -- and you have to meet that every month.

So that's an incentive for overuse of these

things. Additionally, I want to raise, you know, the issue, which I'm sure again you are all aware of, of the increase in proliferation of these has actually been to the detriment of certain hospital facilities, particularly those community hospitals, the smaller hospitals across the state.

Hospitals -- we need hospitals to be open 24/7. We can't just, you know, they can't just close their doors at 6:00 at night. Surgery centers and imaging centers can shut down at 6:00 at night or 8:00 at night and not have to pay for staff overnight just to stay open in case there's an emergency. Hospitals do. And we have to try to balance those capital needs, hospital infrastructure needs which need to be supported and infused with new capital, you know, to keep them operating at sort of the minimum level necessary to support the community.

As I said, the Governor did not move forward with proposing CON, and frankly in part that is because of the various -- the very strong negative reaction to the program as it existed in the '80s, early '90s. But instead, the Governor proposed establishing a commission much like the commission that is proposed in this current bill, but a commission that would actually look at what might

move -- what Pennsylvania might do in moving forward to address the problem. There are alternatives that could be grafted onto a certificate of need-like program that might be very helpful in moving something like this forward.

I think I would just reference at this point while there are over 30 states that use CON or some kind of other regulatory measure to deal with review of facilities and services, certain studies seem to indicate that the most effective of those programs are programs where there are a greater number of denials. And the denial rate varies tremendously across the states. You have very low denial rates, such as in Michigan in 1 percent, in Illinois of 2 percent; a very high denial rates in places like Florida. And the impact of certificate of need particularly as it's reflected in cost increase rates tends to be greater in those states where the denial rate is higher.

Maine has taken a more aggressive approach. And this is an approach that has been very -- of very great interest to our office. In Maine, and I think certainly given our history here in Pennsylvania, the thought was, well, certificate of need by itself isn't really going to work because it's like a pillow. You know, yes, you deny something over here, but cost

increase over here for this other kind of service, and you really can't control how this pillow is going to -- where this pillow is going to rise. Even if you deny a service increase here, it's not going to affect something over here.

So what Maine decided to do was put a cap on everything, put an annual cap on the dollar amount of capital expenditures that can be invested in any given year. And the hospitals, the legislature, the insurance all agreed to this program which started, I believe, two years ago this past summer.

So the data on whether it's succeeding or not are not in quite yet. But the notion is that if you're going to have some kind of process for facilities to get a certificate to allow them to invest in expansion of a facility or expansion of service, you need to be able to show that, A, it's necessary; and B, it's within this aggregate cap across the state.

That exerts a downward pressure on the inclination to try to move certificates of need forward and to approve applications that come in. And you know, Maine very much believes that some kind of downward pressure mechanism is necessary.

I think that, again, you know, the jury is

still out on the Maine program. There are -- because the certificate of need programs vary so widely, there really isn't any good study about whether these things work or not. But I think in going forward we would like to see some core principles addressed in any kind of certificate of need or certificate of need-like approach. And there are four mentioned in the last page of the testimony.

First of all, whatever program goes forward must include a comprehensive planning process to determine what exists, what facilities and service exists, where the needs are, where there is, you know, an oversupply or duplicative services and where there are insufficient services that need somehow to be stimulated to be developed in those areas.

Secondly, there needs to be a mechanism for pushing back against the -- against the inclination to approve applications. Whether it's a global cap such as Maine has, whether we think much more creatively like some kind of cap and trade system like is being proposed for the energy industry, whether we, you know, go the route of the EPA and require cost impact, cost and quality impact statements by those who want to make some kind of major capital investment or there probably other -- other ways to sort of to get a break

on this -- on this investment process and investment rate.

Third, any program must avoid the pitfall, the major pitfall in my view as a lawyer, of the prior program which was that anybody, anybody could appeal a decision. Every person had standing to appeal. That meant that no matter what the decision was, it always ended up in court. Lawyers got rich. I know there are colleagues of mine that would love to see CON come back in its old form because it would be a guaranteed source of income. But I don't think as a policy matter that's where we want to go.

And finally, as has been mentioned before, we really need to keep whatever process is constructed outside the political -- political process so that the decisions are made on a rational basis, not on the basis of politics.

Thank you for the opportunity to appear before you and I'm happy to take questions.

REPRESENTATIVE MANDERINO: Thank you. Representative Godshall.

REPRESENTATIVE GODSHALL: I thank you for your testimony and I wanted to address a couple things that we discussed here today, one of which was a self-referral. And I do remember, will remember back

in a number of years ago when, really, the only way a hospital could get a CAT scan and MRI machine or equipment in was with a doctor's participation. You know, other than that, the people going to that hospital were just denied the service because the hospital just didn't have the money, you know, to put in that equipment.

And in many cases there is physician involvement in that, in putting that equipment in. And it's the only equipment that's available in a given area. So, you know, I have a problem with that.

Another one, you know, I totally agree with you. I do well remember the certificate of need problems we had in the early '90s when in Montgomery County we had a number of hospitals that wanted to compete with Philadelphia as far as services, you know, were concerned. And they were denied. And some of the areas were well-to-do areas, and their residents didn't want to go down to Philadelphia. They wanted to have that service performed at home. It was a totally political atmosphere that existed at that time. And I totally agree with you that it should be avoided, you know, absolutely avoided, you know, if we go into something like this again. It's just got -- we can't get back to that place where we

were before. And so I just wanted to mention that.

And I did want to bring up the self-referral, that sometimes it's absolutely necessary. It's the only way of getting services of this kind of equipment in to a given area. Thank you.

MS. HOLLAND: Thank you.

REPRESENTATIVE MANDERINO: Representative Mundy.

REPRESENTATIVE MUNDY: Thank you. Ms. Holland, I really appreciate your testimony. And I'm glad you address the issue of inflation in health care and why it's not at the same rate as general inflation.

I'm wondering where we are with the Governor's idea of a bipartisan commission of experts. Has that commission been established? Are we going to establish it soon? The Governor only has a couple more years. Let's get with -- let's get on the stick here.

MS. HOLLAND: I would say it has not been established to date. I think the Governor's office will be taking a look at what happens over the next, what is it, six weeks with respect to the program for the uninsured and then move forward on the commission. But we have not -- we have not moved on that to date,

though there have been discussions with the Department of Health about beefing up the planning activity in that department as a sort of a precursor to it, to a commission that could provide technical support to the commission.

REPRESENTATIVE MUNDY: Okay. I've said this before, I'm going to say it again for the record and for the benefit of the Governor and the Office of Health Care Reform. I fully support the Governor's ABC, House Democrat's ABC program. I think it's a major step forward with regard to insuring all Pennsylvanians, even though it doesn't do that. But there is no program -- there is no government program in the world that is going to be able to sustain double digit rate increases, year after year after year. And I commend the Governor for his Hospital Acquired Infections Initiative, for his Scope of Practice Initiatives, and all the other things that he's done that Ms. Bussard mentioned that have addressed some of the issues of costs.

And I just see this as the elephant in the room. And yes, it's very controversial. It can be political. There are interest groups who have enormous amounts of money to gain by not doing anything to prevent people from just willy-nilly

setting up new facilities and buying new equipment. There is enormous money to be made in the status quo, and in my view at the expense of the average citizen. Because the average citizen in my district does not come to me and say I don't -- I can't find a place to have an MRI, I can't get one when my doctor tells me I need one. I can't find a place to have an ambulatory outpatient surgical procedure. That's not what they come to me and say.

What they tell me is they can't afford health insurance. My employers tell me they have to drop health insurance from their list of benefits or that they have to increase copayments. That's what I'm hearing back in my district. If all of these other problems exist in other areas of the state, then -- you know, I don't think northeastern Pennsylvania's that affluent. It's not that poor. But it's middle class citizens who are increasingly having difficulty and getting squeezed out of the health care marketplace. And unless we begin to do something to control the cost, we're never going to be able to afford ABC, you know, adultBasic, or any other health insurance program long term. Thanks for listening.

REPRESENTATIVE MANDERINO: Two quick questions. Earlier, I think it was Paula Bussard

mentioned that while a lot of other states have CON most of their CON is around nursing home. And while we don't call it CON, I think it's fair to say that we have a similar kind of control cap process at DPW with regard to nursing home.

MS. HOLLAND: That's correct.

REPRESENTATIVE MANDERINO: Is there any model there that isn't CON but -- food for thought. You don't need to answer it now. But that was kind of one of my thoughts as we do have a basically cap and we justify need and a cap process with nursing homes already.

MS. HOLLAND: Right. I think that would be -- that's a good point. And that would be food for thought. I think one difficulty is that the DPW is tied to beds and whether beds are Medicaid or not Medicaid. And I believe the position DPW has taken is that if a bed is -- is licensed as a bed it has to be a Medicaid bed. It has to be available for Medicaid purposes. I don't know whether that is the same -- that could -- that would translate over to hospitals in particular. Moreover, the beds are increasingly not the issue because beds, hospital beds per capita are actually declining in Pennsylvania and have been declining steadily since the mid '90s. The issue is

more the non-bed technology, the equipment and that sort of thing.

REPRESENTATIVE MANDERINO: Okay. We closed down MCP. They had a gamma knife.

MS. HOLLAND: Yes, they did.

REPRESENTATIVE MANDERINO: Everybody wanted that gamma knife. Where did it end up?

MS. HOLLAND: I believe it ended up at Presbyterian, but I --

REPRESENTATIVE MANDERINO: Interesting. So whether it -- I knew the answer was going to be an institution. It really doesn't matter which institution. Wouldn't it have been interesting if there was a model that said that gamma knife became a community asset that was somewhere that we didn't have to fight about which institution had it, so which institution got which doctors, so which -- but yet it was -- because my understanding about a lot of this technology, and I remembered about the gamma knife in particular, I mean, that thing could run 23 of the 24 hours a day without any effect on its useful life, but yet it doesn't. And we have five gamma knives in the Delaware Valley instead of one that would probably serve the same.

MS. HOLLAND: Exactly. We actually had some

of those conversations at the Department of Health back in that time period. MCP also had absolutely drop dead gorgeous operating rooms and the health care had invested huge amounts of money into the ORs at that site. They were fabulous. And even though there wasn't the need on -- at that site after MCP went belly up, you know, Temple, you know, rent them out, Temple, Einstein, you know, wherever, you know, to other facilities that may have, you know, a need for them on some kind of rotating or part-time basis. I think that's the kind of creative thinking that needs to be explored.

REPRESENTATIVE MANDERINO: That's what I said to Rick. We need an ambulatory center for the gamma knife that every trained certified physician who can -- brain surgeon who can use that can bear to use it, instead of there being six of them spread all around. Anyway, food for thought.

Thank you so much for your testimony to all the testifiers. And to the members, and as a reminder, we do have another committee hearing tomorrow morning at 10 a.m. on Representative Schroder's house bill -- bills -- house bills whichever. I apologize that I don't have those numbers in front me at the moment. Thank you very

much and we're adjourned.

(Proceedings concluded at 3:47 p.m.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me on the within proceedings and that this is a correct transcript of the same.

Heather L. Artz, RMR, CRR
Notary Public