



BUREAU OF COMPETITION

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

V890025

February 22, 1989

The Honorable Bernice Labeledz
State Senator
Room 2010, State Capitol
Lincoln, Nebraska 68509

COMMISSION AUTHORIZED

Dear Senator Labeledz:

The staff of the Federal Trade Commission¹ is pleased to respond to your invitation to comment on the effectiveness of Nebraska's certificate of need ("CON") regulation of health facilities, and on proposals presently before the Nebraska Legislature to repeal or reform CON regulation. For the reasons discussed below, we believe that Nebraska's current CON regulatory process may, on balance, harm health care consumers. Ongoing improvements in health care financing are resolving the principal problems that prompted CON regulation. Moreover, the benefits of CON regulation, if any, are likely to be outweighed by its adverse effects on competition in health care. As a result, continuing CON regulation is likely to harm consumers by increasing the price and decreasing the quality of health services in Nebraska.

The following comments discuss pending Legislative Bills 429, 439, and 745, all of which propose the substantial liberalization or outright repeal of CON regulation of health facilities in Nebraska.² These comments also discuss the general ineffectiveness of CON regulation in promoting consumer welfare. While we believe the outright repeal of CON regulation proposed in LB 745 would likely best serve the interests of health care consumers, we believe that passage of either of the other CON reform bills would likely also have significant positive effects on health care markets. However, we have reservations about certain aspects of LB 429 and LB 439 that would tighten CON regulation on some types of health facilities and services.

¹ These comments represent the views of the staff of the Bureau of Competition of the Federal Trade Commission, and not necessarily those of the Commission itself or any individual Commissioner.

² Our comments focus on the provisions of the bills affecting the scope and stringency of CON regulation. We do not address the administrative procedural reforms proposed in LB 429 and LB 439.

I. INTEREST AND EXPERIENCE OF THE FEDERAL TRADE COMMISSION

To promote competition in health care markets, the Commission and its staff have been active both in antitrust law enforcement and in competition advocacy. Those efforts have been based on the premise that competition in health care markets, as in other markets, benefits consumers by strengthening incentives for providers to satisfy consumer demands. As a result of these efforts and general economic analyses, the staff of the Commission has gained considerable experience with the economics of health care competition, and the effects of CON regulation.³ Indeed, many of the Commission's antitrust investigations in the health care field focus on competitive problems that would be less severe if there were no CON regulation.⁴

II. THE PROPOSED LEGISLATION

LB 745 is both the simplest and farthest-reaching proposal before the Legislature. That would totally repeal Nebraska's CON statute. It would also amend other statutes to eliminate CON approval requirements for new health services or organizations.

LB 429 would retain Nebraska's system of CON regulation, but with extensive changes. LB 429 would completely remove home health care services from CON regulation. It would also increase the capital expenditures that would trigger CON approval requirements, from zero to \$1.5 million for a "substantial change to an institutional health service," and from \$500,000 to \$1.5 million for other types of capital expenditures. It would also increase from \$250,000 to \$550,000 the annual operating expenditures that would trigger CON approval requirements for a new health service. LB 429 also contains a partial "sunset" provision that would automatically terminate CON regulation of health services other than nursing home-type care on August 1, 1992, unless the Legis-

³ See, e.g., Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. 361 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 107 S. Ct. 1975 (1987); Hospital Corp. of America [Forum acquisitions], 106 F.T.C. 298 (1985) (settled by consent order); American Medical Int'l, Inc., 104 F.T.C. 1 (1984); D. Sherman, The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis (1988) (FTC staff report); M. Noether, Competition Among Hospitals (1987) (FTC staff report); K. Anderson & D. Kass, Certificate of Need Regulation of Entry Into Home Health Care (1986) (FTC staff report). Copies of the three FTC staff reports are enclosed with this letter.

⁴ See Section III.C. below.

lature chooses to continue such regulation.⁵ On the other hand, LB 429 would expand CON coverage to certain conversions of beds in hospital and non-hospital facilities to nursing home-type care.⁶ In addition, LB 429 would eliminate a partial exemption from CON requirements for health maintenance organizations ("HMOs").

LB 439 proposes many of the same changes as LB 429, but is generally more modest in scope. Like LB 429, LB 439 would eliminate CON regulation of home health care services, make extensive changes to CON procedures, and eliminate the partial exemption for HMO facilities. LB 439 would also increase the capital and operating expenditure thresholds triggering CON requirements, though not as much as would LB 429. However, LB 439 would continue CON review for certain new health services, regardless of their capital or operating costs. Those services include not only certain highly sophisticated services usually offered only at major teaching hospitals (e.g., organ transplants and magnetic resonance imaging), but also renal dialysis and ambulatory surgery centers.

III. CON REGULATION IS INEFFECTIVE AND POSSIBLY COUNTER-PRODUCTIVE IN PROMOTING EFFICIENCY IN HEALTH CARE MARKETS

A. CON Regulation Is Unnecessary to Remedy Deficiencies in Health Care Reimbursement

CON regulation was introduced principally on the theory that in the absence of regulation health facilities would expand excessively or purchase unnecessary equipment. The proponents of CON regulation argued that market forces did not sufficiently constrain this tendency because most health care consumers were insured by policies that required little or no out-of-pocket payment, and were therefore generally insensitive to price.⁷ Moreover, third-party payers often reimbursed health facilities on the basis of the costs actually incurred by the facility for the treatment of each patient. This further reduced the incentives the facilities might have had to contain costs.

Health care facilities allegedly had incentives to compete on quality rather than price, to provide wider ranges of

⁵ LB 429 would also change the procedures for CON review.

⁶ LB 429 would not affect the ability of some small, rural hospitals to use some beds for both acute care and skilled nursing care.

⁷ See Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-99, § 103(b), 93 Stat. 592 (1979), repealed, Pub. L. No. 99-660, § 701(a), 100 Stat. 3799 (1986).

diagnostic and therapeutic services and equipment, and more comfortable accommodations.⁸ Health planners expressed concern that the cost of these underutilized, albeit improved, facilities would be passed along to consumers, thereby increasing the cost of health care. Thus, the principal purpose of CON regulation was to control the perceived tendency to provide facilities or services that were not needed.⁹

Substantial changes in health care markets have invalidated many of the assumptions underlying the arguments in favor of CON regulation. Third-party payers and consumers have shown increasing sensitivity to the prices of hospital services. Health maintenance organizations and preferred provider organizations now channel subscribers to physicians and hospitals that offer quality care at economical rates. Conventional health benefit programs provide financial incentives (such as co-payment requirements) that lead their subscribers to seek economical providers, including nonhospital providers.¹⁰ The increasing sensitivity of health care purchasers to the prices of hospital services limits the ability of hospitals to pass on to consumers the costs of facilities and services that are not useful in meeting consumer demands. There has, accordingly, been a trend toward increased price competition among hospitals.¹¹

Programs such as Medicare's "prospective reimbursement" system will reinforce this trend.¹² Medicare now reimburses hospital operating costs at prospective rates that are based principally (and soon exclusively) on flat rates for specific diagnosis related groups (DRGs), rather than on actual costs

⁸ See Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 478-79; M. Noether, note 3 above, at 81.

⁹ See Joskow, Controlling Hospital Costs: The Role of Government Regulation, at 78-79 (1981).

¹⁰ See Insurance Coverage Drives Consumer Prices, Hospitals, Nov. 1, 1985, at 91; see also W. Manning, et al., Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment, 77 American Econ. Review 251 (1987).

¹¹ See, e.g., Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 480-82; Hospital Industry Price Wars Heat Up, Hospitals, Oct. 1, 1985, at 69.

¹² See J. Robinson, et al., Hospital Competition and Surgical Length of Stay, 239 J. Am. Med. A. 696, 700 (Feb. 5, 1988) (prospective payment systems reduce the tendency of hospitals to compete for surgeons by allowing the surgeons to hospitalize patients for longer periods).

incurred.¹³ As such systems are implemented, hospitals rather than third-party payers will bear the costs of any inefficiencies. Hospitals will thus have increased incentives for cost-effective operations. Indeed, the prospect of future reimbursement reforms is already encouraging hospitals to be more efficient.¹⁴

Similar improvements are occurring in other Nebraska health care markets currently subject to CON regulation. For example, Nebraska's Medicaid program, the principal third-party payer for nursing home services, provides significant incentives for nursing home cost containment. Most notably, Medicaid's prospective payment system for nursing homes refuses to reimburse capital and operating costs associated with amounts of unused capacity greater than 15%.¹⁵ Medicaid also disallows costs that are out of line with the average costs of other nursing homes in Nebraska, and gives incentive payments to the most efficient facilities.¹⁶ Thus prospective entrants into nursing home

¹³ Medicare plans to begin reimbursing capital costs in a somewhat similar manner. See 42 U.S.C.A. § 1395ww(a)(4), (d) (West Supp. 1987); 52 Fed. Reg. 18840 (1987) (proposed regulation to phase in flat prospective rates for capital costs over three years for movable equipment, and over ten years for other capital costs). But see Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4006(b)(1), 101 Stat. 1330-52 (1987) (delaying implementation of prospective reimbursement for capital-related costs until 1991). See also Modern Healthcare, Aug. 1, 1986, at 20; Health Care Competition Week, Jan. 12, 1987, at 4.

¹⁴ See, e.g., Raske, Association Seeks Sound Capital Pay Policy, Modern Healthcare, Nov. 7, 1986, at 120 (uncertainty about future of reimbursement for capital expenses is encouraging hospitals to make more conservative capital investment decisions for inpatient services).

¹⁵ See Neb. Admin. R. 12-011.06B, .06C ("allowable costs" per nursing home patient day computed on basis of the greater of actual occupancy or 85 percent occupancy, unless nursing home is less than a year old). It appears that as a result of this requirement, and Medicaid regulations governing specific reimbursement elements, Medicaid pays only costs allocated to nursing home beds actually used by its beneficiaries, and some of the costs of unused beds up to 15 percent of a facility's total beds, but none of the costs of higher levels of unused beds.

¹⁶ See Neb. Admin. R. 12-011.07D1, .07D4 (ceiling on operating cost component of reimbursement set at 110 percent of average operating costs of all nursing home facilities of same care classification; nursing homes with non-nursing operating

(continued...)

markets have no substantial incentive from Medicaid to build more capacity than they can reasonably expect to use. Existing firms also have strong incentives to serve patients more effectively to keep their capacity fully utilized. Moreover, price competition for nursing home patients who pay for their own care deters nursing homes from imposing excessive costs upon those patients.¹⁷ Similarly, price competition and well-structured governmental and private reimbursement programs limit incentives for over-investment and other wasteful expenditures for other health services and facilities that are currently subject to CON regulation, such as home health care services, ambulatory surgery centers, and renal dialysis centers.¹⁸

B. CON Regulation Has Been Ineffective
as a Cost-Containment Mechanism

It is not clear that CON regulation has promoted the efficient delivery of health care services, as intended.¹⁹ A number of empirical studies suggest that CON regulation has not controlled general acute care hospital costs. Early studies found that instead of constraining overall hospital costs, CON regulation may have simply caused hospitals to reallocate their resources, constraining some costs while other costs

¹⁶(...continued)
costs below statewide average granted up to \$1 additional reimbursement per patient day).

¹⁷ See A. Lee, H. Birnbaum & C. Bishop, How Nursing Homes Behave: A Multi-Equation Model of Nursing Home Behavior, 17 Social Science and Medicine 1897, 1905 (1983) (private patient demand for nursing home services is price sensitive).

¹⁸ See, e.g., K. Anderson & D. Kass, note 3 above (home health care); 52 Fed. Reg. 20466 (1987), 52 Fed. Reg. 20623 (1987) (Medicare reimburses freestanding ambulatory surgery centers at flat prospective rates, and will soon provide half the reimbursement for hospital outpatient surgery on the same basis (with the other half cost-based)); 51 Fed. Reg. 29404 (1986) (Medicare reimburses outpatient renal dialysis care at flat prospective rates).

¹⁹ It is true, of course, that if the CON process significantly reduces the level of capital investment below the level that would otherwise exist, total health care costs will be less. This is undesirable, however, to the extent that health care services for which consumers would be willing to pay are not supplied or the prices of services rise above competitive levels.

increased.²⁰ Later studies also concluded that CON regulation did not reduce costs per unit of hospital output.²¹ Finally, several studies, including two recent FTC staff reports, concluded that CON regulation is associated with higher hospital costs.²² These studies suggest that CON laws do not contain costs, and in fact may increase them.²³

Supporters of CON regulation sometimes point to the dollar amount of projects denied, withdrawn or modified as a result of the CON process as an indication of the value of CON regulation. These amounts, however, are not necessarily an accurate measure of the "excessive" capital investment deterred, because CON regulation may cause the filing of applications for more projects than would actually be carried out in an open market.

CON regulation forces firms to compete for a limited number of certificates of need. Because the certificates are granted on a showing of "need," applicants may assume that any CON granted

²⁰ Salkever & Bice, Hospital Certificate-of-Need Controls: Impact on Investment, Cost, and Use (1979); Salkever & Bice, The Impact of Certificate-of-Need Controls on Hospital Investment, 54 Milbank Mem. Fund Q. 185 (1976).

²¹ Policy Analysis, Inc.-Urban Systems Engineering, Inc., Evaluation of the Effects of Certificate of Need Programs (1980); Steinwald & Sloan, Regulatory Approaches to Hospital Cost Containment: A Synthesis of the Empirical Evidence, in American Enterprise Inst., A New Approach to the Economics of Health Care (1981).

²² D. Sherman, note 3 above, at iv, 78; M. Noether, note 3 above, at 74, 82. These studies used data from all 50 states but from different time periods, each comparing states by type of regulation. F. Sloan & B. Steinwald, Effects of Regulation on Hospital Costs and Input Use, 23 J. L. & Econ. 81 (1980); C. Coelen & D. Sullivan, An Analysis of the Effects of Prospective Reimbursement on Hospital Expenditures, 3 Health Care Financing Review 1 (1981). These studies, in addition to comparing data across states, also compared costs before and after the enactment of CON regulation in various states. See also K. Anderson & D. Kass, note 3 above, at 87-92 (CON does not decrease, and may increase, the cost of home health care).

²³ A 1986 FTC staff report reached a similar conclusion about the effect of CON regulation on home health care services. K. Anderson & D. Kass, note 3 above, at 87-92 (1986). In addition, a study of the economic behavior of nursing homes found evidence that CON regulation increases, rather than decreases, the average cost of nursing home services. A. Lee, H. Birnbaum & C. Bishop, note 17 above, at 1906.

reduces the likelihood that a similar CON will be granted to another applicant. This generates pressure to file preemptively or defensively (particularly under combined review, where applications for similar projects are required to compete for a limited number of approvals). When several applicants pursue one available CON, that does not mean that in the absence of CON regulation all proposed projects would have been carried out. The applicants may realize that demand exists for only one project. Therefore, the denial of all applications but one would not represent actual savings in capital costs.

Moreover, some applicants may not be committed to carrying out their proposed project even if selected. An applicant may be protecting its perceived long-run interests or may simply be filing to delay or frustrate other applications. Therefore, the number of applications denied, withdrawn, or modified may substantially overstate actual deterrence.

C. CON Regulation Interferes with Competition and Innovation in Health Care Markets

CON regulation, on balance, may be counterproductive to efforts to control health care costs. As discussed below, the CON regulatory process imposes substantial costs on applicants, because of the effort required to obtain regulatory approval and the delays occasioned by the regulatory process. To the extent that CON regulation reduces the supply of particular health services below competitive levels, the prices of these services can be expected to be higher than they would be in an unregulated market.²⁴ Curtailing services or facilities may create shortages, forcing some consumers to resort to more expensive or otherwise less desirable substitutes. For example, a shortage of nursing home beds can delay the discharge of

²⁴ Where prices are regulated, the "price increase" may take the form of reductions in service quality, so that consumers receive services of lesser value for the same price, instead of paying more money for the same services.

Severe shortages of capacity can protect firms that provide substandard service from competitive pressures to upgrade performance and from regulatory pressures to adhere to licensure requirements. For example, a state agency may be reluctant to close a nursing home for major violations of licensure requirements if the patients cannot be placed elsewhere. See J. Feder & W. Scanlon, Regulating the Bed Supply in Nursing Homes, 58 Milbank Memorial Fund Q. 54, 76 (1980).

patients from more expensive general acute care hospital beds²⁵ or force patients to use nursing homes far from home.

The CON regulatory process may lead to higher prices by protecting firms from competition by innovators and new entrants.²⁶ The CON process reduces the possibility of entry by firms that could provide services of higher quality or lower cost than existing firms, and that perhaps could displace firms that do not effectively meet consumer needs. Although the CON process does not always prevent the entry or expansion of health facilities or services, it generally places the burden on new entrants to demonstrate that a need is not being served by those currently in the market. In addition, the process of preparing and defending a CON application is often costly and time-consuming (particularly if the application is opposed by firms already in the market).²⁷ CON regulation may also create opportunities for existing firms to abuse the regulatory process to prevent or delay new competition.²⁸ CON regulation, therefore, makes entry and expansion less likely, or at least less rapid. Firms in a market need not be as competitive in price or as sensitive to consumer demand for new services if they know that it will be difficult and expensive for new firms to enter and offer competitive prices or services.

Because CON regulation at least increases the cost and time required for new entry and expansion, it increases the likelihood that existing providers will exploit whatever market

25 U.S. General Accounting Office, Constraining Health Care Expenditures: Achieving Quality Care at Affordable Cost, at 93-94 (1985).

26 Posner, Certificate of Need for Health Care Facilities: A Dissenting View, in Regulating Health Facility Construction at 113 (C. Havighurst, ed. 1974); M. Noether, note 3 above, at 82 (CON restrictions on entry are associated with hospital price increases of approximately 4 to 5 percent and hospital cost increases of approximately 3 to 4 percent).

27 See Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 490-92.

28 T. Calvani & N. Averitt, The Federal Trade Commission and Competition in the Delivery of Health Care, 17 Cumberland L. Rev. 293, 298-99 (1987) (discussing potential for health providers to use CON process for "non-price predation"); St. Joseph's Hospital v. Hospital Corp. of America, 795 F.2d 948, 959 (11th Cir. 1986) (defendants' misrepresentations to state health planning body concerning plaintiff's CON application not protected from antitrust scrutiny); Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 492.

power they have, individually or collectively, to raise prices above (or reduce quality below) the competitive level.²⁹ That is why the Federal Trade Commission, in its opinions in hospital merger cases, has cited the entry barrier created by CON regulation as a factor significantly contributing to the potential for anticompetitive effects from the mergers.³⁰

CON regulation may also interfere with competition by delaying the introduction and acceptance of innovative alternatives to costly treatment methods. Regulators may lack the information to determine how many such facilities are needed, or may not respond rapidly enough to changing market conditions. For example, action on all CON applications for freestanding ambulatory surgical centers ("FASCs") in Pennsylvania was delayed by six months while a CON task force reviewed the need for these facilities.³¹ Demand for ambulatory surgery can be difficult to predict because the market is changing rapidly. Provider firms have financial incentives that regulators lack to gather information and to adjust rapidly to unexpected changes in costs or demand. For these reasons, reliance on market forces is likely to provide more rapid and desirable responses to changing conditions than CON regulation would allow.

²⁹ This is most likely to occur where there are few competing providers in a particular market, see Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 487-89, such as in rural areas, or for certain hospital specialty services.

³⁰ American Medical Int'l, Inc., 104 F.T.C. at 200-01 (1984); Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 489-96, and 807 F.2d at 1387.

Some shared service arrangements, consolidations, and other joint provider activities could significantly threaten competition unless the prospect of new entry would keep the market competitive by making any significant price increases unsustainable. CON regulation can thus conflict with health planning objectives by limiting providers' freedom to pursue efficiencies without also creating unacceptable risks of anticompetitive effects.

³¹ Pennsylvania Legislature, Budget & Finance Committee, Report on a Study of Pennsylvania's Certificate of Need Program at 14 (Feb. 1987). FASCs offer an innovative, less costly alternative to hospital surgical facilities. Evidence suggests that the growth of FASCs generally has been hampered by the CON process. Ermann & Gable, The Changing Face of American Health Care, 23 Medical Care 401, 407 (1985).

IV. REPEAL OR SUBSTANTIAL LIBERALIZATION OF CON
REGULATION IN NEBRASKA WOULD HAVE A BENEFICIAL
EFFECT ON COMPETITION AND CONSUMERS

For the reasons discussed above, we believe the continuation of CON regulation in Nebraska may adversely affect competition in the state's health care markets, increasing the price and decreasing the quality of health care services. We believe that the total elimination of CON regulation, as proposed in LB 745, is the best alternative available to the Legislature.

If the Legislature does not eliminate CON regulation entirely, reductions in the coverage of CON restrictions, such as those set forth in the principal provisions of LB 429 and LB 439, would likely reduce the adverse effects of CON regulation. Raising CON coverage thresholds, as LB 429 and (to a lesser extent) LB 439 would do, should substantially reduce the burden of CON regulation by eliminating review of relatively small capital expenditures, equipment purchases, and other investments in new services.³² A 1988 report by the staff of the FTC's Bureau of Economics suggests that hospitals in states with higher CON thresholds have lower overall costs.³³ Moreover, the provisions of LB 429 and LB 439 that would eliminate CON regulation of home health care services are especially likely to benefit consumers, since the need for CON regulation of home health care is particularly questionable.³⁴

While we believe the principal substantive reform provisions of LB 429 and LB 439 would be likely to yield substantial bene-

³² LB 439, however, would limit the beneficial effect of its threshold increases by requiring CON review of all projects to establish certain specified health services, including not only costly services such as organ transplants, but also the much less costly dialysis and ambulatory surgical center services. We think flat-rate Medicare reimbursement policies put more pressure on health care facilities to be efficient, and reduce the need for CON regulation of dialysis and ambulatory surgery. See note 18 above; FTC Staff Comments to Maryland Health Resources Planning Comm'n re: Draft Ambulatory Services Section of Maryland State Health Plan (Aug. 6, 1987). (A copy of the MHRPC comments is enclosed with this letter.)

³³ D. Sherman, note 3 above, at vi, 7, 59-60, 78.

³⁴ See K. Anderson & D. Kass, note 3 above; see also H.R. Rep. No. 96-190, 96th Cong., 1st Sess. at 53 (1979) (House committee considering amendments to federal health planning law found CON regulation of home health care unwarranted because market forces adequately constrain and allocate supply); Havighurst, Deregulating the Health Care Industry at 193-202 (1982).

fits to consumers, we have reservations about some provisions in those bills that would tighten CON regulation of particular types of health care projects. For example, both LB 429 and LB 439 would remove the partial exemption from CON review for HMO facilities. This would extend CON regulation into an area where it is unlikely to serve any useful purpose. HMOs have particularly strong incentives to avoid wasteful investments in facilities and equipment, since they have no opportunity to shift the costs of their mistakes to other third-party payers. Largely because HMOs have such strong incentives to be efficient, in 1979 Congress enacted an exemption to the National Health Planning and Resources Development Act to allow state CON programs to leave HMO facilities and services unregulated in most cases.³⁵

We are also concerned about the provision in LB 429 for expanded CON review of transfers into long-term care of unused bed capacity at institutions other than nursing homes, including particularly the substantial unused capacity in the medium-to-large or urban hospitals ineligible for LB 429's "swing bed" exception.³⁶ To the extent that such conversions are currently possible without CON review but would be subjected to review by LB 429, such new regulation would likely interfere with a particularly inexpensive method of adding to long-term care capacity to compete with existing nursing homes.

V. CONCLUSION

We believe that the continued existence of CON regulation would be contrary to the interests of health care consumers in Nebraska. Ongoing changes in the health care financing system, including prospective payment mechanisms and increased consumer price sensitivity fostered by private insurers, are eliminating the principal concerns that prompted CON regulation. Moreover, the CON regulatory process does not appear to serve its intended purpose of controlling health care costs. Indeed, CON regulation may be counterproductive, because it interferes with competitive

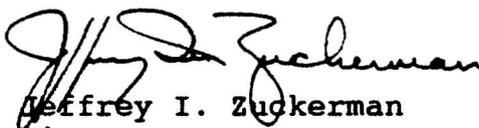
³⁵ Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-99, § 117(a), 93 Stat. 615-17 (1979), repealed, Pub. L. No. 99-660, § 701(a), 100 Stat. 3799 (1986); S. Rep. 96-96, 96th Cong., 2d Sess. at 79-80 (1979); see also Havighurst, note 34 above, at 213-36.

³⁶ See American Hospital Ass'n, 1988 Hospital Statistics, at 94; American Hospital Ass'n, 1988 AHA Guide at A201-A205; LB 429, sec. 15 (proposed new Neb. Rev. Stat. § 71-5830(4)). LB 429 would not affect conversions of small amounts of bed capacity (the lesser of 10 beds or 10 percent of a facility's total beds). However, it would affect larger conversions not currently subject to review because they are accomplished without capital expenditure.

market forces that would otherwise help contain costs. CON regulation tends to foster higher prices, lower quality, and reduced innovation in health care markets. The elimination of such regulation, as proposed in LB 745, or its substantial liberalization, as proposed in LB 429 and to a lesser extent in LB 439, would be likely to benefit Nebraska health care consumers.

We appreciate the opportunity to present these comments. We would be happy to answer any questions you may have regarding these comments and to provide any other assistance you may find helpful.

Sincerely yours,


Jeffrey I. Zuckerman
Director
Bureau of Competition

Enclosures:

The Effect of State Certificate-of-Need Laws on
Hospital Costs: An Economic Policy Analysis (1988)

Competition Among Hospitals (1987)

Certificate of Need Regulation of Entry Into Home
Health Care (1986)

FTC Staff Comments to Maryland Health Resources Planning
Commission re: Draft Ambulatory Services Section of
Maryland State Health Plan (August 1987)