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FEDERAL TRADE COMMISSION
WASHINGTON, D. C. 20580

COMMISSION AUTHORIZED

BUREAU OF ECONOMICS

August 6, 1987

Ms. San Cheang
Maryland Health Resources Planning Commission
201 West Preston Street, 1st Floor
Baltimore, Maryland 21201

Dear Ms. Cheang:

The Staff of the Federal Trade Commission (FTC)[1] is pleased to respond to your request for comments on the draft Ambulatory Surgical Services Section of the Maryland State Health Plan. That draft section sets forth your proposed policy respecting the application of Certificate-of-Need (CON) regulations to proposals for the construction and expansion of ambulatory surgical centers in hospitals and in freestanding facilities. For the reasons discussed below, we believe that CON regulations are, in general, unnecessary in Maryland, and that they are particularly unnecessary for ambulatory surgery facilities. We also believe that certain specific features of the Plan may impede adjustments to changing market conditions and discourage the establishment of freestanding ambulatory surgical units even when they may be more efficient than hospital ambulatory surgery. For these reasons, we believe that the proposals are likely to raise the overall costs of ambulatory surgery, reduce competition in the market for health services, and harm consumers.

Our comments first address the justification for and effects of CON regulations in general.[2] We then examine the specific justification for CON regulation of ambulatory surgical services, and follow this with an examination of particular regulations suggested in the draft Plan. In general, we conclude that you should rely on the market to the extent possible.

I. Interest and Experience of the Federal Trade Commission

For more than a decade, the FTC has engaged in extensive efforts to preserve and promote competition in health care markets. The FTC and its staff have been active both in antitrust law enforcement (including litigated

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[1] These comments represent views of the Bureaus of Competition, Consumer Protection, and Economics of the Federal Trade Commission, and do not necessarily represent the views of the Commission or of any individual Commissioner. The Commission has, however, voted to authorize the submission of these comments.

[2] We recognize that the Maryland Health Resources Planning Commission is not in a position to repeal CON laws. We believe, however, that discussion of the purpose and effects of CON regulations is necessary for the efficient implementation of specific proposals.

staff have been active both in antitrust law enforcement (including litigated cases and non-public investigations)[3] and in commenting on regulatory reforms,[4] recognizing that competition in health care service markets, like other markets, will generally benefit consumers by strengthening the incentives for providers to satisfy consumer demands. As a result of FTC antitrust enforcement efforts, as well as economic analysis of CON regulation,[5] the FTC staff has gained considerable experience with the economics of health care competition, and with the manner in which health planning regulation affects that competition. Indeed, a significant part of the FTC's antitrust law enforcement effort in the health care field is devoted to competitive problems that would not exist, or would be less severe, if there were no CON regulation.[6]

II. CON Regulation Is Unnecessary To Constrain Health Care Costs, and Repeal of CON Laws Will Promote Competition and Benefit Consumers

CON regulation of health care providers has traditionally been based on the theory that unregulated competition would result in the unnecessary construction or expansion of facilities, or in other unnecessary capital expenditures. The assumption underlying this theory is that health care providers have an inherent tendency to expand or purchase equipment unnecessarily. It is thought that this alleged tendency is not sufficiently constrained by market forces because insured patients are covered by policies that require little or no out-of-pocket payment, thereby making them insensitive to the price of medical services. Moreover, health care providers are often reimbursed by third-party payers on a retrospective cost basis, which reduces their incentive to contain costs.

As a result of these forces, competition among health care providers traditionally may have taken place in terms of quality rather than price, although some price competition has existed.[7] Providers had an incentive to offer wider ranges of diagnostic and therapeutic services and equipment, and more comfortable facilities, to attract additional patients and physicians,

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[3] See, e.g., Hospital Corp. of America, 106 F.T.C. 361 (1985), aff'd 807 F.2d 1381 (7th Cir. 1986), cert. denied, 107 S.Ct. 1975 (1987); American Medical Int'l, Inc., 104 F.T.C. 1 (1984).

[4] See, e.g., FTC staff letter to Mr. Giri Vuppala, Health Systems Agency of New York City, February 9, 1987; FTC staff letters to Congresswoman Mary George, Hawaii State Senate and Congressman Fred Hemmings, Hawaii State House of Representatives, March 13, 1987.

[5] See, e.g., K. Anderson and D. Kass, Certificate of Need Regulation of Entry Into Home Health Care (FTC Staff Report, 1986); M. Noether, Competition Among Hospitals (FTC Staff Report, 1987).

[6] See Hospital Corp. of America, supra, 106 F.T.C. at 489.

[7] See Id., at 478-79. But see also Noether, supra, at 81-88, who found that there was some price competition among hospitals even in 1977-78.

even if the new facilities were underutilized. The initial concern expressed by health planners was that the expenditures on these facilities would be passed along to consumers, thereby increasing overall health care costs. The purpose of CON regulation was not to assure that facilities were placed where needed; rather, it was to control the perceived tendency to provide duplicative facilities or services.[8]

As a result of significant changes in health care markets in recent years, however, many of the assumptions that may have supported arguments in favor of CON regulation are no longer valid.[9] There has been a trend toward increased competition, particularly price competition, among health care providers.[10] Third-party payers and consumers now are clearly not insensitive to the prices of health care services. Conventional health benefit programs now generally provide subscribers with financial incentives (such as co-payments) to patronize low-cost providers, including non-hospital providers.[11] In addition, health maintenance organizations and preferred provider organizations are well-positioned to channel subscribers to health care providers offering lower rates. Moreover, the recent trend toward use of prospective payments, such as reimbursement by Medicare based on diagnostic related groups rather than individual hospitals' actual costs, has required health care providers to become more cost conscious, since some costs are no longer reimbursable. All these changes appear likely to deter health care providers from creating excess capacity and making long term capital investments whose financial feasibility depends on the ability to shift costs to third-party payers.[12]

An additional reason for concern over CON regulations is provided by empirical evidence suggesting that such laws have not had the intended effect of controlling unnecessary health care expenditures. Early studies

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[8] See P. Joskow, Controlling Hospital Costs: The Role of Government Regulation (1981).

[9] Indeed, the United States Congress recently repealed the National Health Planning and Resources Development Act of 1974, which had provided incentives and penalties to encourage states to enact CON regulations. See P.L. 99-660, sec 701 (1986).

[10] See, e.g., Hospital Corp. of America, supra, 106 F.T.C. at 480-82; Hospital Industry Price Wars Heat Up, Hospitals, Oct. 1, 1985, at 69. See Noether, supra, at 81-89.

[11] See W.G. Manning, J.P. Newhouse, A. Liebowitz, N. Duan, E.B. Keeler, and M.S. Marquis, Health Insurance and the Demand for Medical Care, 77 American Economic Review, (June 1987), at 267-8, and Insurance Coverage Drives Consumer Prices, Hospitals, Nov. 1, 1985, at 91.

[12] See Raske, Association Seeks Sound Capital Pay Policy, Modern Healthcare, Nov. 7, 1986, at 120.

found that CON regulation did not constrain overall health care costs.[13] Rather, the CON regulatory process may have caused some hospitals to make substantial capital investments in areas not covered by CON controls.[14] Later studies reached similar conclusions, finding that the CON laws did not affect costs per unit of hospital output.[15] A recent FTC Bureau of Economics study examining hospitals during 1977-78 suggests that CON laws have led to higher expenditures by hospitals.[16] Similarly, the FTC's Bureau of Economics found in another study that CON regulation of home health care agencies increases the cost of home health care to consumers.[17]

Furthermore, there is evidence that CON regulation can raise health care prices, whether or not it causes an increase in costs.[18] If the effect of the regulation is to restrict the supply of health care services provided by existing firms or new entrants, and particularly if it restricts innovative suppliers, prices will be higher than they would be in an unregulated competitive environment.[19] Although the CON process does not formally prohibit entry or expansion, or the development of new services, it generally places the burden on new entrants to demonstrate that a "need" is not being served by those currently in the market. Even if an application is ultimately approved, the process of preparing and defending a CON application is often extremely costly and time consuming. Incumbent firms may not need to be as sensitive to price or to consumer demand for new services if they know that it will be difficult and expensive for new firms to enter the market and offer competitive prices or services.

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[13] Salkever and Bice, Hospital Certificate-of-Need Controls: Impact on Investment, Cost, and Use (1979); Salkever and Bice, The Impact of Certificate-of-Need Controls on Hospital Investment, 54 Milbank Memorial Fund Q. 185 (Spring 1976).

[14] Id. While hospitals kept down their investments in beds, total hospital assets per bed were found to increase.

[15] Policy Analysis, Inc.-Urban Systems Engineering, Inc., Evaluation of the Effects of Certificate of Need Programs (1980). See also Steinwald and Sloan, Regulatory Approaches to Hospital Cost Containment: A Synthesis of the Empirical Evidence, in A New Approach to the Economics of Health Care (1981); Feldstein, Health Care Economics (1983), at 275-83.

[16] See Noether, supra, at 82.

[17] See Anderson and Kass, supra.

[18] Posner, Certificate of Need for Health Care Facilities: A Dissenting View, in Regulating Health Facility Construction 113 (C. Havighurst, ed. 1974). See also Feldstein, supra, at 278 and Noether, supra, at 82.

[19] 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 a higher price for the same services.

Finally, under some circumstances, CON regulation can facilitate the attainment of anticompetitive objectives[20], including supracompetitive prices. It has also been argued that competitors may misuse the CON regulatory process for the purpose of excluding potential competitors from entering the market.[21]

III. CON Regulation of Ambulatory Surgical Care Is Especially Unnecessary

The usual justification for CON laws, the avoidance of duplicative facilities and services, rests in part on assumptions that the provision of new services entails large expenditures on equipment or facilities, and that the market for those services is characterized by a lack of price competition. These assumptions, however, do not appear to apply to ambulatory or outpatient surgery, or to freestanding ambulatory surgical centers (FASCs).

The provision of ambulatory surgery services entails lower expenditures on equipment than does inpatient surgery. Inputs with high fixed costs, such as general anesthesia, are often unnecessary for ambulatory surgery. The rapid growth of ambulatory surgery conducted in physicians offices is indicative of the small scale at which these services are often provided.[22] One commentator has concluded that because the existing capacity of FASCs does not exceed their use and that the costs of FASCs are not excessive for the quality of services provided. He concludes that "the reasons usually given for CON legislation, such as excess capacity, are lacking in the case of these substitute services."[23]

In the absence of CON regulations, the low fixed costs of starting an ambulatory surgery unit could be expected to permit relatively easy entry into the market for ambulatory surgery services, thereby encouraging price competition.[24] Furthermore, third-party payers, such as Blue Cross and Blue Shield, have recently encouraged outpatient surgery to promote cost

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[20] Hospital Corp. of America, supra, at 497-98.

[21] See, e.g., 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). See also, Hospital Corp. of America, supra, at 492.

[22] See e.g., State Health Plan: Ambulatory Surgical Services, draft, section .01, B(2).

[23] See Feldstein, supra, at 278.

[24] For discussion of low fixed costs and ease of entry in another health care market, see Anderson and Kass, supra.

savings.[25] The movement toward a prospective reimbursement orientation by Maryland's Health Services Cost Review Commission with respect to hospital ambulatory surgery, and by Medicare with respect to ambulatory surgery in freestanding units, also encourages competition.[26]

CON regulation of ambulatory surgery is, however, likely to discourage its use as a substitute for inpatient surgery. While the express goal of the draft State Health Plan is to encourage ambulatory surgery, CON regulations tend to raise the price of medical services by limiting their availability.[27] Higher prices will discourage the use of ambulatory surgery where it might otherwise substitute for inpatient surgery, thus increasing overall health care costs.

IV. Provisions in the State Health Plan Are Likely To Raise Overall Costs of Ambulatory Surgery

The specific policies set forth in the Plan are likely to raise the overall costs of ambulatory surgery. In particular, the Plan discourages certain types of ambulatory surgical facilities that may be of lower cost or more appropriate in certain circumstances, and does not provide sufficient flexibility for adapting rapidly to the changes in technology and consumer demand.

Policies in the Plan that encourage the growth of ambulatory surgery in hospitals relative to FASCs are likely to increase the costs of ambulatory surgery overall. This inducement to hospitals occurs through the priority given to projects that convert existing hospital capacity over projects involving new construction (policy 2), and the priority given to ambulatory surgery facilities that provide an array of procedures (policy 7).[28] Giving preference to hospital ambulatory surgical facilities over other types of ambulatory surgical units may discourage the growth and entry of less costly alternatives.

Several studies indicate that FASCs have lower ambulatory surgery

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[25] See, e.g., Consumer Exchange, Blue Cross and Blue Shield, March 1987, which discusses attempts to substitute ambulatory surgery in physician offices for many procedures done in hospitals.

[26] See e.g. 52 Fed. Reg., at 20466; 52 Fed. Reg., at 20623.

[27] See Ermann and Gabel, The Changing Face of American Health Care, Medical Care, 1985, at 407. They report that CON regulation has been one of the primary factors inhibiting growth of FASCs.

[28] Since hospitals generally have the equipment necessary to conduct many types of surgery, it is expected that hospitals are more likely to be able to provide an array of procedures than FASCs.

costs than do hospitals.[29] FASCs would be more appropriate and lower cost for some types of surgery (such as cases in which access to the wide range of facilities and sophisticated equipment offered in hospitals is unnecessary). Unless there are safety or other quality justifications, it is important not to favor one form of ambulatory surgical care over another, because doing so may raise costs to consumers.

There are other reasons why FASCs should not be discouraged from providing ambulatory surgery. While loss of patients to FASCs may temporarily reduce hospitals' revenues, overall costs of health care will fall if outpatient surgery is less costly. Competition from FASCs will reduce the ability of hospitals to pass along costs of excess capacity to consumers and will encourage hospitals to reduce excess capacity to the extent this is possible. In this way, FASCs play an important role in promoting MHPRC's goal of encouraging economical ambulatory surgery. We suggest that you delete policies from the Plan that favor hospital ambulatory surgical units over FASCs and rely on the market to a greater extent.

A final problem that arises in the draft Plan is the difficulty in predicting the demand for ambulatory surgery. As pointed out in the Plan, ambulatory surgery is rapidly becoming more accessible due to improvements in technology and greater acceptance by physicians. These trends are difficult to predict and, in fact, the formulas for future projections that are suggested in the Plan do not explicitly incorporate these factors. While the Maryland Health Resources Planning Commission might provide information or guidance on future trends, firms have incentives to gather their own information and to adjust rapidly to unexpected changes in trends. The need to meet CON requirements will delay adjustments in this rapidly growing and changing market. For these reasons, reliance on market forces rather than some type of enforced plan is likely to provice greater flexibility in adapting to changing conditions.

V. Conclusion

Changes in the health care financing system, including prospective payment mechanisms and increased consumer price sensitivity fostered by private insurers, have undermined the original rationale for CON regulation of medical facilities. Moreover, a number of studies have concluded that the CON regulatory process does not appear to serve its intended purpose of controlling health care costs. Rather, it reduces the competitive constraints on costs and prices that the market provides in the absence of regulation.

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[29] The Plan cites a study by Miller. The Plan also mentions problems with this study, but other studies report similar findings, including those by Detmar, Ambulatory Surgery, New England Journal of Medicine, 1981, at 1406-9, and Wolff and Dunnihoo, A Free-standing Ambulatory Surgical Unit: A Success or Failure, Journal of Obstetrics and Gynecology, 1982, at 270-76. Note Finkler, Changes in Certificat-of Need Laws: Read the Fine Print in Incentives vs. Controls in Health Policy (1985), at 132-45; Ermann and Gabel, supra, at 407-9.

The application of CON regulations to ambulatory surgery is likely to increase costs to consumers. As currently drafted, specific proposals in the Plan are likely to limit price reductions for ambulatory surgery. Further, the implementation of the Plan may hinder market developments that provide consumers with the optimal level of medical services consistent with technological developments. For all of these reasons, we believe that the costs associated with CON regulation of ambulatory surgery probably exceed the benefits.

We hope that these comments have been helpful. If we can be of any further assistance, please contact us.

Sincerely,

David T. Scheffman

David T. Scheffman
Director
Bureau of Economics