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UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
ATLANTA REGIONAL OFFICE

V890020

COMMISSION AUTHORIZED

February 6, 1989

The Honorable Culver Kidd
State Senate
Room 453
State Capitol
Atlanta, Georgia 30334

Dear Senator Kidd:

The staff of the Federal Trade Commission[1] is pleased to comment on Senate Bill 133 ("S.B. 133"), Senate Bill 134 ("S.B. 134"), Senate Bill 135 ("S.B. 135"), Senate Bill 136 ("S.B. 136"), and Senate Bill 137 ("S.B. 137"), each of which would partially reduce the current scope of Certificate of Need ("CON") regulation in Georgia. Although the proposed legislation would only partially relax Georgia's CON requirements, passage, in our view, may lead to greater diversity and better quality in health care services and increased price competition in the health care market. The bills' successful implementation might also pave the way for further reductions in Georgia's "need-based" regulation of health care.

We will focus our comments on the five proposed bills as well as the general ineffectiveness of CON laws in promoting the welfare of health care consumers. For the reasons discussed below, we believe that Georgia's current CON regulatory process may, on balance, harm health care consumers. Ongoing improvements in health care financing are resolving the principal problems that allegedly 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 markets. As a result, CON regulation may have a negative effect, increasing the price and decreasing the quality of health services in Georgia.

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[1] These comments represent the views of the staff of the Federal Trade Commission's Atlanta Regional Office and of the Bureau of Competition, and not necessarily those of the Commission itself or any individual Commissioner.

I. INTEREST AND EXPERIENCE OF THE FEDERAL TRADE COMMISSION

For more than a decade, the Federal Trade Commission has engaged in extensive efforts to preserve and promote competition in health care markets. The Commission and its staff have been active both in antitrust law enforcement and in advocacy of regulatory reforms, including CON reforms previously considered or proposed in Georgia.[2] 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 health care consumer demands. Although we have not conducted empirical studies of the effects of CON regulation in Georgia, the staff of the Commission have studied the effects of CON regulation in general and gained considerable experience with the economics of health care competition and with how CON regulation affects that competition.[3] Indeed, a significant part of the Commission's antitrust law enforcement effort in the health care field focuses on competitive problems that would be less severe if there were no CON regulations.[4]

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[2] On March 4, 1988 we submitted comments to Senator Kidd on then - pending Senate Bill 398. The bill would have exempted from the CON process for a period of one year the offering of new clinical health services by health care facilities. Much of the analysis contained in that letter is repeated here.

[3] See, e.g., 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); and K. Anderson & D. Kass, Certificate of Need Regulation of Entry Into Home Health Care (1986) (FTC staff report).

[4] See, e.g., Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. 361, 489-96 (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); and American Medical Int'l, Inc., 104 F.T.C. 1 (1984).

II. THE PROPOSED LEGISLATION

S.B. 133 would exempt from CON requirements the acquisition by a health care facility[5] of diagnostic or therapeutic equipment to replace or upgrade existing equipment if (a) the replacement or upgrading equipment does not result in the offering of any new clinical health services[6] and (b) the value of the replacement or upgrading equipment does not exceed $1.2 million. Passage of this bill would enable hospitals and other health care facilities to replace or upgrade their present equipment with the newest, most innovative equipment whenever they believe it is in the best interest of their patients and their competitive positions to do so.

S. B. 134 would exempt from CON coverage "new institutional health services"[7] provided by nursing homes or specialty

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[5] Georgia law defines "health care facility" to include seven kinds of facilities: (1) hospitals; (2) other special care units, including podiatric facilities, skilled nursing facilities, and kidney disease treatment centers, including freestanding hemodialysis units; (3) intermediate care facilities; (4) personal care homes not in existence on the effective date of this chapter; (5) ambulatory surgical or obstetrical facilities; (6) health maintenance organizations; and (7) home health agencies. Georgia Code (1985) § 31-6-2(8).

[6] "Clinical health services" means diagnostic, treatment, or rehabilitative services provided in a health care facility, or parts of the physical plant where such services are located in a health care facility, and includes, but is not limited to, radiology; radiation therapy; surgery; intensive care, whether intermediate, skilled, or extended care; cardiac catheterization; open-heart surgery; inpatient rehabilitation; and alcohol, drug abuse, and mental health services. Georgia Code (1985) § 31-6-2(5)

[7] In general, "new institutional health service" means:

(A) The construction, development, or other establishment of a new health care facility;

(B) Any expenditure by or on behalf of a health care facility in excess of $600,000 which, under generally accepted accounting principles consistently applied, is a capital expenditure;

(C) Any increase in the bed capacity of a health care

hospitals engaged exclusively in providing services to head-injured persons and having 50 or fewer beds. This would permit the health care sector to establish beds and facilities (currently lacking in Georgia) for the long term care of head-injured persons if the health care market determines that a need for such facilities exists.

S.B. 135 would remove "personal care homes"[8] from the CON process, thus restoring market forces to part of the health care industry that provides care to the elderly. Once a need for such facilities is demonstrated, private industry could presumably move quickly to accommodate that need.

S.B. 136 would provide that the "need" for medical or surgical beds should not be a consideration in determining

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facility;

(D) Clinical health services which are offered in or through a health care facility, which were not offered on a regular basis in or through such health care facility within the 24 month period prior to the time such services would be offered;

(E) Any conversion or upgrading of a facility such that it is converted from a type of facility not covered by [CON} to any of the types of health care facilities that are covered by [CON]; or

(F) The purchase or lease by or on behalf of a health care facility of diagnostic or therapeutic equipment with a value in excess of $400,000. Georgia Code (1985) § 31-6-2(14)

[8] The present statute defines "personal care home" as a residential facility having at least 25 beds and providing, for compensation, protective care and oversight of ambulatory, nonrelated persons who need a monitored environment but who do not have injuries or disabilities which require chronic or convalescent care. Personal care homes may provide medical, nursing, or intermediate care. Personal care homes include those facilities which monitor daily residents' functioning and location, have the capability for crisis intervention, and provide supervision in areas of nutrition, medication, and provision of transient medial care. S.B. 135 would also remove the 25 bed restriction. Georgia Code (1985) § 31-6-2(18) It is our understanding, based on conversations with Senator Kidd's staff and our own reading of the statute, that this definition does not cover traditional nursing homes.

whether to grant a certificate for a new institutional health service offered or developed by a hospital if that service would not increase medical or surgical bed capacity. Based on the definition of "new institutional health services," this provision would appear to permit hospitals to offer new clinical health services, make capital expenditures in excess of $600,000, offer new health care facilities, and purchase diagnostic or therapeutic equipment with a value in excess of $400,000 without CON approval so long as there is no increase in bed capacity. Passage of this bill would appear to greatly increase the discretion of hospitals as to how best to allocate their resources to meet consumer demand.

S.B. 137 would exempt from CON coverage capital expenditures to renovate a hospital or replace any part of a hospital if the project does not result in any new clinical health service or any increase in bed capacity. Passage of this provision would allow hospitals to make their own judgments as to when renovation would enable them to compete for and provide better services to patients.

For the reasons discussed below, we believe that Georgia's CON regulation may be contrary to the interests of health care consumers. Thus, reductions in the scope of that regulation (such as those contained in SBs 133 - 137), are likely to benefit Georgia health consumers.

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 of health facilities was introduced principally on the theory that unregulated competition would result in the construction of unnecessary facilities or unnecessary capital expenditures by existing health facilities. The assumption underlying this theory was that health facilities had a tendency to expand excessively or purchase unnecessary equipment. The proponents of CON regulation argued that this tendency was not sufficiently constrained by market forces because most consumers of health care were insured by policies that required little or no out-of-pocket payment, making consumers generally insensitive to the price of health care

services.[9] Moreover, third-party payers often reimbursed health facilities on a retrospective cost basis, removing whatever incentive the facilities might have had to contain costs.

Health care facilities allegedly had incentives to compete on the quality rather than the price of their services, although limited price competition existed. Health care facilities thus faced artificially created incentives to expend resources to provide wider ranges of diagnostic and therapeutic services and equipment, and more comfortable accommodations.[10] The concern expressed by health planners when CON regulation was created was that the cost of underutilized, albeit improved, facilities would be passed along to consumers, thereby increasing the cost of health care. The principal purpose of CON regulation was not to assure that needed facilities would be built when they otherwise would not have been; rather, it was to control the perceived tendency to provide facilities or services that were not needed.[11]

In light of substantial changes in health care markets, many of the assumptions underlying the various arguments in favor of CON regulation now have lost any validity they might once have had. Third-party payers and consumers have shown increasing sensitivity to the prices of hospital services. Health maintenance organizations and preferred provider organizations, through selective contracting, channel subscribers to physicians and hospitals offering quality care at economical rates. Improvements in conventional health benefit programs also provide their subscribers with financial incentives (such as co-payment requirements) that channel these subscribers toward economical providers, including nonhospital providers.[12] The increasing sensitivity of health care purchasers to the prices of hospital

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9 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).

10 See Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 478-79; M. Noether, supra note 3, at 12-13.

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

12 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).

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.[13]

Programs such as Medicare's "prospective reimbursement" system will reinforce this trend.[14] Medicare presently 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 the actual costs incurred by a particular hospital for its Medicare patients.[15] As this system, and others like it, are implemented, the costs of any inefficiencies will be paid increasingly out of the hospitals' own budgets rather than those of third-party payers and individual consumers, providing hospitals the incentive for cost-effective provision of services. Indeed, the prospect of future reimbursement reforms is already encouraging greater efficiency on the part of hospitals.[16] Similarly, price

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13 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.

14 See J. Robinson, et al., Hospital Competition and Surgical Length of Stay, 239 J. Am. Med. A. 696, 700 (Feb. 5, 1988). (One of the ways that hospitals compete for surgeons is by offering to allow the surgeon to hospitalize his patients longer than he could hospitalize them in other hospitals. Prospective payment systems counteract the tendency to compete in this way.

15 Of course, the issue in CON regulation is capital costs, not operating costs, but in 1991 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); Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, Section 4006(b)(1), 101 Stat. 1330-52 (1987) (amending 42 U.S.C.A. § 1395ww; delays implementation until 1991). See also Modern Healthcare, Aug. 1, 1986, at 20; Health Care Competition Week, Jan. 12, 1987, at 4.

16 See 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

competition and well-structured governmental and private reimbursement programs appear to limit incentives for over-investment and other wasteful expenditures for at least some of the other, nonhospital, types of health facilities subject to CON regulation in Georgia.[17]

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

It is not clear that CON regulation has had the intended effect of containing health care costs.[18] A number of empirical studies suggest that CON regulation has not controlled general acute care hospital costs. Early studies of CON regulation found that instead of constraining overall hospital costs, it may have simply caused hospitals to reallocate their resources. Thus, while some types of hospital costs were constrained by CON regulation, other costs increased.[19] Later studies reached

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inpatient services).

[17] See, e.g., 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)).

[18] It is true, of course, that, if the CON process significantly reduces the level of capital investment in hospitals, equipment, and other assets below the level that would otherwise obtain, total health care costs will be less. Whether this is desirable, however, depends on the extent to which the reduction in the output of particular health care services due to the CON-imposed constraint is due to limitations on capital investments that are feasible only because costs can be shifted to third-party payers. If additional investment is curtailed, then the regulation will harm consumers. Some health care services for which consumers would have been willing to pay enough to cover the capital and other attendant costs of providing will not be supplied. In addition, the prices of each of the particular services whose supply is curtailed by the regulation will rise above competitive levels.

[19] 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 Memorial Fund Q 185 (Spring 1976).

similar conclusions, finding that CON regulation did not reduce costs per unit of hospital output.[20] Finally, several studies, including two recent FTC staff reports, concluded that CON regulation is associated with higher hospital costs.[21] These studies suggest that as a means of cost containment, CON laws may be, at best, ineffective and, at worst, cost-increasing.[22]

Supporters of CON regulation sometimes point to the dollar amount of projects denied, withdrawn or modified as a result of the CON process as demonstrating the regulation's utility. However, these amounts do not necessarily represent a savings in the overall cost of health care. Nor do they necessarily represent an accurate measure of the amount of "excessive" capital investment deterred. While CON regulation may deter some capital spending that would occur in an unregulated environment, the amount of this deterrence is difficult to measure because CON

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20 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 A New Approach to the Economics of Health Care, American Enterprise Institute (1981).

21 D. Sherman, supra note 3, at iv, 78; and M. Noether, supra note 3, 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. 81-109 (1980); and C. Coelen & D. Sullivan, An Analysis of the Effects of Prospective Reimbursement on Hospital Expenditures, 3 Health Care Financing Review 1-40 (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, supra note 3, at 87-92 (CON does not decrease, and may increase, the costs of home health care agencies).

22 In addition, a 1986 FTC staff report reached a similar conclusion about the effect of CON regulation on home health care services. K. Anderson & D. Kass, supra note 3, at 87-92 (1986). Also, a 1983 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, How Nursing Homes Behave: A Multi-Equation Model of Nursing Home Behavior, 17 Social Science and Medicine 1897, 1906 (1983).

regulation may cause an increase in the filing of project applications.[23]

Similarly, CON supporters point to the number of denied applications to show that CON regulation is helping to hold down health care costs. But CON regulation simply forces firms to compete for a limited number of certificates of need. Just because several applicants pursue one available CON certificate does not mean that in the absence of CON regulations all proposed projects would be carried out, because demand for more than one such project may not exist. Thus, the denial of all applications but one would not represent actual savings in capital costs. Moreover, some of the applicants may not be committed to carrying out the project even if selected. An applicant may be simply filing an application to delay or frustrate another applicant. Thus, the number of applications denied, modified or withdrawn may substantially overstate actual deterrence. Furthermore, deterrence of some capital spending by CON regulation may not yield an overall savings in health care costs since costs may increase in other areas not covered by CON regulation, as suggested by some of the studies mentioned above.[24]

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 itself imposes substantial costs on applicants, in terms of both 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 in an

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[23] Because need must be demonstrated, applicants may assume that any CON granted reduces the likelihood that a similar CON will be granted to another applicant. Such an assumption generates pressure to file pre-emptively or defensively.

[24] See sources cited supra, notes 19 and 20, and Anderson & Kass, supra note 3, at 87-92. See also C. Havighurst, Regulation of Health Facilities and Services by "Certificate of Need," 59 Virginia L. Rev. 1143, 1218 (1973).

unregulated market.[25] Curtailment of available services or facilities may create shortages, forcing some consumers to resort to more expensive or otherwise less desirable substitutes, thus increasing costs for third-party payers or patients. For example, a shortage of nursing home beds can delay the discharge of patients from more expensive general acute care hospital beds[26] or force patients to use nursing homes far from home.

CON regulation can substantially interfere with competition in health care markets in three additional ways. First, the CON regulatory process may increase prices to consumers by protecting firms in the market from competition by innovators and new entrants.[27] The CON process reduces the possibility of entry by more efficient firms that could provide higher quality or lower cost services, and, possibly, replace less efficient providers. Although the CON process does not always prohibit the entry or expansion of health facility enterprises, 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. In addition, the process of preparing and defending a CON application is often costly and time-consuming (particularly if the application is opposed by

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25 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, not only from competitive pressures to upgrade performance, but also from regulatory pressures to adhere to licensure standards. For example, a state agency may be reluctant to close a nursing home for major violations of licensure standards 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, at 76 (1980).

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

27 R. Posner, Certificate of Need for Health Care Facilities: A Dissenting View, in Regulating Health Facility Construction at 113 (C. Havighurst, ed. 1974); M. Noether, supra note 2, at 82 (CON restrictions on entry are associated with hospital price increases of approximately 4 to 5 percent, as well as increases in hospital costs of approximately 3 to 4 percent).

firms already in the market).[28] CON regulation may also create opportunities for existing firms to abuse the regulatory process to prevent or delay new competition.[29] CON regulation, therefore, makes entry and expansion less likely, or at least less rapid. Firms in any given 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 the market and offer competitive prices or services.

By increasing the cost and time required for new entry and expansion, CON can interfere with competition in a second way. Incumbent providers, insulated from new competition, may be better able to exercise whatever market power they have, either individually or collectively, and raise prices above (or reduce quality below) the competitive level.[30] The entry barrier created by CON regulation was a factor significantly contributing to the potential for anti-competitive effects from the mergers[31] at issue in both of the hospital merger decisions rendered by the Federal Trade Commission in litigated cases. In the Chattanooga acquisitions opinion, the Commission found that

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[28] An evaluation of the CON program in Michigan found that the number and complexity of CON appeals increased dramatically from 1979 to 1986. Comparative reviews were found to be particularly protracted. Michigan Statewide Health Coordinating Council, An Evaluation of the Certificate of Need Program, (March 19, 1987) at 29-34; see also Hospital Corp. of American [Chattanooga acquisitions], 160 F.T.C. at 490-92.

[29] T. Calvani & N. Averitt, The Federal Trade Commission and Competition in the Delivery of Health Care, 17 Cumberland L. Rev. 283, 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 acquisition], 106 F.T.C. at 492.

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

[31] American Medical Int'l, 104 F.T.C. at 200-01 (1984); Hospital Corp. of American [Chattanooga acquisitions], 106 F.T.C. at 489-96, aff'd, 807 F.2d 1381, 1387 (7th Cir. 1987).

the combination of Tennessee's CON process and Georgia's CON restrictions on hospital entry inhibited new entry that might have deconcentrated the Chattanooga hospital market.

The third way in which CON regulation may interfere with competition is by delaying the introduction of new treatment methods because regulators may lack the information necessary to determine how many such facilities are needed. 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.[32] Demand for ambulatory surgery can be difficult to predict because the market is changing and changing rapidly. Providers have market 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 greater flexibility in adapting to changing conditions while the need to meet CON requirements will delay adjustments in rapidly growing and changing markets.

IV. ENACTMENT OF SENATE BILLS 133, 134, 135, 136, AND 137 WOULD REPRESENT A BENEFICIAL, THOUGH LIMITED, REDUCTION IN GEORGIA'S CON REGULATION. IF THE CON PROCESS IS TO BE RETAINED, IT COULD BE FURTHER IMPROVED SO AS TO MINIMIZE ITS NEGATIVE IMPACT ON COMPETITION AND CONSUMERS

For the reasons discussed above, continuation of the CON process in Georgia may have an adverse effect on competition in the state's health care markets, increasing the price and decreasing the quality of health care services. If so, then repeal of the CON process would be advantageous. In the meantime, passage of each of the pending bills is likely to result in a beneficial reduction in the costs that CON regulation imposes on health care consumers in Georgia.

Several other improvements short of outright repeal of the CON process might also be considered. One such reform could be to raise the monetary thresholds above which CON approval is required. This could reduce the burden of CON regulation by

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32 Budget & Finance Committee of the Pennsylvania Legislature, Report on a Study of Pennsylvania's Certificate of Need Program, Feb. 1987 at 14. 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, Medical Care, 1985, at 407.

eliminating the need to review minor capital expenditures and equipment purchases and facilitate the development of lower-cost alternatives to inpatient care.[33] A 1988 report by the FTC's Bureau of Economics suggests that hospitals in states with higher CON thresholds have lower overall costs.[34]

A second reform would be for the legislature to limit the number of new kinds of health services subject to CON review. This may also lower costs by removing restrictions on entry.

A third reform would be to delete from CON coverage certain kinds of facilities that appear most likely to encourage competition and innovation in health care. For example, a staff report by the Commission's Bureau of Economics, concluded that CON regulation of entry into home health care did not result in lower costs, and may have increased costs and restricted entry.[35] Therefore, home health care may be a good prospect for deletion from coverage. The legislature may thus wish to consider this and other facilities for elimination from CON coverage.

CONCLUSION

We believe that the continued existence of CON regulation may be contrary to the interests of health care consumers in Georgia. 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 problems 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 counter-productive because it interferes with competitive market forces that would otherwise help contain costs. CON regulation tends to foster higher prices, lower quality, and reduced innovation in health care markets. We conclude that enactment of Senate Bills 133, 134, 135, 136, and 137 by the General Assembly would likely have beneficial consequences for Georgia health care consumers.

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33 M. Lerner, et al., Investigation of Certain Issues in Connection With the Virginia Certificate of Need Law at VII, 12 (final report, Aug. 10 1987).

34 D. Sherman, supra note 3, at vi, 7, 59-60, 78.

35 K. Anderson & D. Kass, supra note 3.

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,

Paul K. Davis by JLR

Paul K. Davis
Director
Atlanta Regional OfficeB: