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COMMISSION AUTHORIZED

March 30, 1988

The Honorable John F. Pressmann and
The Honorable Donald W. Snyder
State Representatives
House Post Office Box 114
Main Capitol Building
Harrisburg, Pennsylvania 17120-0028

Dear Representatives Pressmann and Snyder:

The staff of the Federal Trade Commission[1] is pleased to respond to your invitation to comment on House Bill 1328, repealing the Certificate of Need (CON) process in Pennsylvania, and on the effectiveness of CON laws generally in promoting consumer welfare. Although we have not conducted empirical studies that are specific to Pennsylvania, for reasons discussed in greater detail below we believe that continued CON regulation is unlikely to benefit health care consumers in Pennsylvania. 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 the adverse effects of such regulation on competition in health care markets. Consequently, continuing CON regulation is likely to harm consumers by increasing the price and decreasing the quality of health services in Pennsylvania.

We recognize that the legislature may, for a variety of reasons, choose to retain the CON process. If it does, then certain changes, such as increasing the thresholds on covered expenditures and removing certain types of facilities from coverage, may decrease the negative effects of CON regulation. In addition, a sunset provision would ensure that CON regulation will be re-evaluated soon in light of new developments.

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[1] These comments represent the views of the Federal Trade Commission's Bureaus of Competition, Consumer Protection and Economics, and of the Cleveland Regional Office, and not necessarily those of the Commission itself or any individual Commissioner. The Commission has, however, voted to authorize the staff to submit these comments to you.

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. Those efforts are based on the premise that competition in health care service markets, like other markets, will benefit consumers by strengthening incentives for providers to satisfy consumer demands. As a result of Commission antitrust law enforcement efforts and economic analyses of the effects of CON regulation, the Commission's staff has gained experience with the economics of health care competition and the ways in which CON regulation affects that competition.[2] Indeed, a large part of the Commission's antitrust law enforcement efforts in the health care field focuses on competitive problems that would not exist, or would be less severe, if there were no CON regulation.[3]

II. 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 ground 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

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[2] *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 these three FTC staff reports are enclosed with this letter.

[3] *See* Section II.C. below.

consumers generally insensitive to the price of health care services.[4] Moreover, third-party payers often reimbursed health facilities on a retrospective cost basis, removing whatever incentive the facilities might have had to contain costs.

These forces allegedly generated an incentive for health care facilities to compete on the quality rather than the price of their services, although limited price competition existed. Health care facilities had incentives to expend resources to provide wider ranges of diagnostic and therapeutic services and equipment, and more comfortable accommodations.[5] The concern expressed by health planners when CON regulation was created was that the cost of these improved, albeit under-utilized, 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.[6]

In light of substantial changes in health care markets, many of the assumptions underlying arguments in favor of CON regulation appear to have lost their validity. 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.[7] 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

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[4] *See* Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-99, § 103(b), 93 Stat. 592 (1979), *repealed*, Pub. L. No. 99-960, § 701(a), 100 Stat. 2799 (1986).

[5] *See* Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 478-79; M. Noether, *supra* note 2, at 81.

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

[7] *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).

demands. There has, accordingly, been a trend toward increased price competition among hospitals.[8]

Programs such as Medicare's "prospective reimbursement" system will reinforce this trend.[9] Medicare presently reimburses hospital operating costs at prospective rates which 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.[10] As this system, and others like it, are implemented, the costs of any inefficiencies will be paid increasingly out of the hospitals' own pockets rather than those of third-party payers and individual consumers, providing hospitals the incentive for cost-effective provision of service. Indeed, the prospect of future reimbursement reforms is already encouraging greater efficiency on the part of hospitals.[11]

Improvements similar to these are occurring in some Pennsylvania health care markets currently subject to CON regulation. For example, reimbursement of nursing homes in Pennsylvania by Medicaid, an important third-party payer for nursing home services, now provides significant incentives for cost containment, particularly with respect to the construction of new capacity. Most notably, the Medicaid program refuses to bear capital and operating costs associated with more than a small amount of unused capacity. This deprives prospective entrants into nursing home markets of any Medicaid incentive to build more capacity than they can reasonably expect to use. It also gives existing firms strong incentives to serve patients more effectively so they can

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[8] *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.

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

[10] 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); *see also Modern Healthcare*, Aug. 1, 1986, at 20; *Health Care Competition Week*, Jan. 12, 1987, at 4. *But see* Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4006(b)(1), 101 Stat. ___ (1987) (delays implementation of prospective reimbursement for capital-related costs until 1991).

[11] *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 inpatient services).

keep their capacity fully utilized.[12] Moreover, price competition for nursing home patients who pay for their care from their own funds deters nursing homes from imposing excessive costs upon those patients.[13] Similarly, price competition and/or well-structured governmental and private reimbursement programs limit incentives for over-investment and other wasteful expenditures for at least some of the other types of health facilities subject to CON regulation in Pennsylvania.[14]

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. A number of empirical studies suggest that CON regulation has not controlled general acute care hospital costs by preventing expenditures for unnecessary beds, services, and equipment.[15] Early studies of the effects of CON regulation found that instead of constraining overall hospital

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[12] 55 Pa. Code § 1181.233 (1983). As we understand it, Pennsylvania Medicaid computes capital and operating cost reimbursement per Medicaid patient day, in most instances, by dividing a nursing home's allowable costs by the number of patient days per year the nursing home would have had if it operated at a 90 percent occupancy rate (or, if greater, the actual number of patient days). As a result, Medicaid pays only costs allocated to the capacity used by its beneficiaries, except that it bears some of the costs of unused capacity not exceeding 10 percent of total capacity. Other states pay for even a smaller amount of unused capacity. (Pennsylvania Medicaid also imposes ceilings on reimbursable operating costs of nursing homes, and awards incentive payments to nursing homes with operating costs below the ceilings.)

[13] *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, at 1905 (1983) (private patient demand for individual nursing homes' services is price elastic).

[14] *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)).

[15] 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 2, at 87-92 (1986). A study of the economic behavior of nursing homes, which did not focus on the effectiveness of CON regulation, noted that CON regulation appeared to increase, rather than decrease, the average cost of nursing home services. A. Lee, H. Birnbaum & C. Bishop, *supra* n.14, at 1906 (1983).

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.[16] Later studies reached similar conclusions, finding that CON regulation did not reduce costs per unit of hospital output.[17] Finally, several studies, including two recent FTC staff reports, concluded that the presence of CON regulation is associated with higher hospital costs.[18] These studies suggest that as a means of cost containment, CON laws may be, at best, ineffective and, at worst, cost-increasing.

A 1987 assessment of Pennsylvania's CON program, while noting that health care costs in the Commonwealth have risen as fast as the national average, found that the CON program in Pennsylvania has been effective in

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[16] 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).

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 attributable to these factors 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 advances the regulation's proffered justification – the curtailment of capital investments that are financially feasible only if costs can be shifted to third-party payers. If additional investment is curtailed, then some health care services for which consumers would have been willing to pay more than is necessary to cover all of the capital and other attendant costs of providing them will nonetheless 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.

[17] 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).

[18] D. Sherman, *supra* note 2, at iv, 78; and M. Noether, *supra* note 2, 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* Anderson & Kass, *supra* note 2, at 87-92 (CON does not decrease, and may increase, the costs of home health care agencies).

avoiding certain costs because certificates of need have been denied, withdrawn or modified as a result of the CON process.[19] The report also warned of "the possibility of unbridled capital spending" should CON be repealed based on the experience of other states -- notably, Arizona and Utah, which repealed their CON requirements.[20]

However, the dollar amount of projects denied, withdrawn or modified as a result of the CON process does not necessarily represent a savings in the overall cost of health care, nor does it necessarily represent an accurate measure of the amount of "excessive" capital investment deterred. While CON regulation may deter some of the capital spending which would occur in an unregulated environment, the amount of this deterrence is difficult to measure because CON regulation may cause the filing of project applications in excessive numbers.

CON regulation forces firms to compete for a limited number of certificates of need.[21] Simply because several applicants pursue one available CON does not mean that in the absence of CON regulation all proposed projects would be carried out, since 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 protecting what it perceives as the institution's long-term interests or may simply be filing an application to delay or frustrate the other. Thus, the dollar amount 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.[22]

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[19] Legislative Budget & Finance Committee, Report on a Study of Pennsylvania's Certificate of Need Program, Feb. 1987 (hereinafter "LBFC Report"), at 18-20, 22-23. Elsewhere, the report referred to these as "demonstrated cost savings." *Id.* at 4.

[20] *Id.* at 3.

[21] This is particularly true where applications are subject to comparative review. Even for applications not subject to comparative review, since the burden is on the applicant to demonstrate need, 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.

[22] *See* sources cited *supra*, notes 16 and 17, and Anderson & Kass, *supra* note 2, at 87-92. *See also* C. Havighurst, Regulation of Health Facilities and Services by "Certificate of Need," 59 *Virginia L. Rev.* 1143, at 1218 (1973).

The prediction that "an unbridled surge" in unnecessary capital spending will occur if CON regulation is repealed is based on early reports of the experience of Arizona and Utah with CON repeal.[23] However, a more detailed analysis of the post-CON events in these states shows most increases in construction which did occur were likely to have been short-term and in areas which were under-served.[24] For example, Arizona's "surge" in nursing home construction began even before CON expired – when its bed-to-over-65-population ratio was the lowest in the nation and substantially below the national average – and continued during a period when the State experienced substantial in-migration of aged persons.[25] Also, an initial study of the effects of CON repeal in Arizona reported a strong surge in applications for hospital projects, but a later study found, however, that much of the planned construction did not materialize.[26] The Johns Hopkins Report found that Utah experienced an increase, but not a "surge" in nursing home construction, while new hospital construction was limited to freestanding psychiatric hospitals.[27] The Report concluded that the change to a prospective payment system by Medicare had diminished the incentives toward new capital investment by hospitals.[28]

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[23] LBFC Report at 21. While we argue in this paragraph that predictions of increased hospital and nursing home construction are overstated, it should not be inferred that we consider such construction to be undesirable. As we have discussed in previous sections, CON regulation restricts supply, so it is expected that construction will occur where supply has not kept pace with demand. On the other hand, if there is an over-supply in a particular area (*e.g.*, acute care hospital beds) new construction is unlikely to occur.

[24] M. Lerner, *et al.*, Investigation of Certain Issues in Connection With the Virginia Certificate of Need Law at VI, 9-17, 27-40; VII, 5-7 (final report, Aug. 10, 1987) (hereinafter "Johns Hopkins Report").

[25] *Id.* at VII, 12, 27.

[26] Results of both studies are summarized, *id.* at VII, 5. Arizona did experience substantial growth in the number of open-heart surgery units, but other states that repealed CON did not. *Id.* at VII, 10.

[27] *Id.* at VI, 12-13, 16.

[28] *Id.* at VI, 14-16. The experience of Arizona, Utah, Kansas and Texas is summarized at VII, 5-6. The Report concludes that "indications from these four states are that substantial growth in hospital beds is unlikely on CON sunset." *Id.* at VII, 6.

Just as Medicare is influencing capital investment decisions by hospitals, state Medicaid reimbursement policies are an important influence on the growth of nursing homes. *Id.* at VI, 13-14 and VII, 14-15 (states with very high occupancy ratios can expect an increase in construction or conversion of beds

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

CON regulation, on balance, is probably not merely ineffective but actually counterproductive in its contribution to the control of 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, their prices can be expected to be higher than they would be in an unregulated market.[29] Curtailment of available services or facilities may create shortages which force some consumers to resort to more expensive or otherwise less desirable substitutes, thus increasing costs for third-party payers and/or patients. For example, a shortage of nursing home beds can delay the discharge of patients from more expensive general acute care hospital beds[30] or force patients to use nursing homes far from home.

Even if CON regulation does not yield acute shortages of services, it can substantially interfere with competition in health care markets. First, the CON regulatory process may increase prices to consumers by protecting firms in the market from competition by innovators and new entrants.[31] Although the CON

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upon CON repeal, but the level of Medicaid reimbursement is an important influence on the amount of growth, along with other factors, such as the existing bed-to-population ratio and the geographic distribution of existing beds). Because Pennsylvania already has in place Medicaid reimbursement policies that should deter unnecessary nursing home construction in the event of CON repeal, an "unbridled surge" in such construction seems unlikely to occur. *See* pp. 4-5, *supra.*

[29] 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 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, at 76 (1980).

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

[31] 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

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. This reduces the possibility of entry by more efficient firms which would provide higher quality and/or lower cost services and, possibly, replace the less efficient firms. 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).[32] CON regulation may also create opportunities for existing firms to abuse the regulatory process so as further to prevent or delay new competition.[33] 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.

Second, by reducing the likelihood of (or at least increasing the cost and time required for) entry and expansion, CON regulation can make it more likely that providers will exploit whatever market power they have, individually or collectively, to raise prices above (or reduce quality below) the competitive level.[34] That is why, in both of the hospital merger decisions issued by the Federal Trade Commission in litigated cases, the Commission cited the entry

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hospital price increases of approximately 4 to 5 percent, as well as increases in hospital costs of approximately 3 to 4 percent).

[32] 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 America [Chattanooga acquisitions], 106 F.T.C. at 490-92.

[33] T. Calvani & N. Averitt, The Federal Trade Commission and Competition in the Delivery of Health Care, 17 *Cumberland L. Rev.* 293, at 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, at 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.

[34] 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.

barrier created by CON regulation as a factor significantly contributing to the potential for anti-competitive effects from the mergers.[35] CON regulation can thus render anti-competitive otherwise lawful conduct, and aggravate the anti-competitive effects of antitrust violations.[36]

Third, CON regulation may delay the introduction and acceptance of innovative alternatives to present costly 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.[37] It is difficult to predict demand for ambulatory surgery because it is rapidly becoming more accessible to patients due to improvements in technology and greater acceptance by physicians. While state health-planning agencies might provide information or guidance on future trends, provider firms have incentives to gather their own information (*e.g.*, by paying for market research) and to adjust rapidly to unexpected changes in trends. 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.

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[35] 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, *aff'd*, 807 F.2d 1381, at 1387 (7th Cir. 1987).

[36] In particular, the entry barriers created by CON regulation can transform into possible antitrust violations potentially efficient joint activities by health care providers that would otherwise be lawful. For example, in some cases shared service arrangements and consolidations could significantly threaten competition, unless the prospect of new entry would keep the market competitive by making any significant, sustained price increases unprofitable. CON regulation can thus conflict with the achievement of health planning objectives by limiting the freedom of providers to pursue efficiencies without also creating unacceptable risks of anti-competitive effects.

[37] LBFC Report 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.

D. CON Regulation Is Not a Good Method For Assuring Access to Care for Indigent Patients.

It has also been suggested that CON regulation must be retained in order to protect access to care for indigent patients. According to this theory, CON regulation prevents the construction of facilities that would siphon off paying patients, leaving those facilities that treat indigent patients with no way to make up their losses.[38] Under this view, CON regulation should be retained precisely because it insulates providers from competition.

CON regulation, however, may not be the best means of assuring that care is available for indigent patients. CON regulation, in effect, imposes a "hidden tax" on consumers of health services in the form of higher prices. That "tax" may be more costly to society than conventional forms of taxation because of its interference with health facility competition; moreover, the burden of that "tax" falls disproportionately on those in poor health.[39] The legislature may wish to consider alternative mechanisms for funding care for indigent patients that would not impair the efficient functioning of health care markets as CON regulation does.[40]

E. Other Justifications for Continuing CON Regulation Are Insufficient.

It has been suggested that CON regulation be retained for a limited period of time so that the weight of increased use of HMOs and PPOs and improved consumer information can be felt in the marketplace.[41] For example, the lack of availability of consumer information has been cited as a reason for continuing CON regulation until the Pennsylvania Health Care Cost Containment Council is able to provide comprehensive information on health care quality and cost. The Council projects that such information would be available no sooner than two years from now.[42] However, while the Commonwealth eventually may

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[38] LBFC Report at 4-5.

[39] *See* R. Posner, Taxation by Regulation, 2 *Bell J. of Econ.* 22 (1971); C. Havighurst, *supra* note 22, at 1188-94.

[40] For example, rural hospitals whose viability (and ability to serve the indigent) is threatened by declining occupancy rates could be encouraged to convert beds to long-term care. Johns Hopkins Report at VII, 13. The same Report summarizes efforts by the states to find alternative methods for funding indigent patient care. *Id.* at part VII, 23-24, citing FAHS Review, "Review's 1986 State-by-State Survey: A Special Report," Sept./Oct. 1986 at 27-42.

[41] LBFC Report at 4, 27.

[42] LBFC Report at 27.

be able to provide some consumer information, health care providers and other groups have clear incentives to provide consumer information and can be expected to provide more of it as the market becomes more competitive. These incentives to provide information should increase in the absence of the CON process which insulates providers from competition. Therefore, retention of CON regulation may actually reduce the amount of available health care information.

It also has been suggested that a sunset provision in a revised CON law would allow for a fresh look at the state of the health care market, including health care alternatives and consumer information, in a few years.[43] While we agree that a sunset provision is appropriate if the CON process is to be retained, we emphasize that repeal of CON regulation is a preferable means of enhancing consumer welfare.

III. IF THE CON PROCESS IS RETAINED, IT SHOULD BE IMPROVED TO MINIMIZE ITS NEGATIVE IMPACT ON COMPETITION AND CONSUMERS.

The LBFC Report also recommends that the legislature raise the thresholds for CON review, reduce the list of new health services subject to CON review, and expand review of purchases of major medical equipment. If repeal of CON is not feasible at this time, raising coverage thresholds and reducing the number of new health services subject to CON review may alleviate in part some of the negative effects of CON regulation. However, we question the necessity of expanding coverage of purchases of major medical equipment to providers currently not subject to CON.

Raising coverage thresholds as the LBFC Report recommends[44] will reduce the burden of CON regulation by eliminating the need to review minor capital expenditures and equipment purchases. It would facilitate the growth of lower-cost alternatives to inpatient care.[45] A 1988 report by the FTC's Bureau of Economics suggests that hospitals in states with higher CON thresholds actually have lower overall costs.[46]

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[43] *Id.* at 15.

[44] The LBFC Report (at 8-9) recommends increasing the current threshold of $760,495 to between $1.5 million and $2 million.

[45] Johns Hopkins Report at VII, 12.

[46] D. Sherman, *supra* note 2, at vi, 7, 59-60, 78.

Limiting the number of new health services subject to review may also have the effect of lowering costs since it removes restrictions on entry. The LBFC Report recommends covering new health services only if they exceed the coverage threshold for capital expenditures or if they have been shown to require a certain volume of use in order to maintain quality. We suggest that the Legislature also consider whether some new health services should be exempted from coverage even if they entail a capital expenditure in excess of the threshold.[47]

The reason given for broadening CON coverage of major medical equipment purchases is that, currently, substantial numbers of such purchases are made by providers, such as physicians' offices, that are not subject to CON review.[48] However, broadening CON coverage to include these providers may not be warranted. Physicians' groups and other providers not reimbursed on a retrospective-cost basis for capital expenditures would have much weaker incentives than do hospitals to make excessive capital investments. Thus, CON review of their proposed expenditures offers little prospect of public benefit while imposing costs both on the providers (complying with the process) and the public (administering it).

IV. CONCLUSION.

We believe that the continued existence of CON regulation would be contrary to the interests of health care consumers in Pennsylvania. 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 problem that prompted CON regulation. Moreover, the CON regulatory process does not appear to serve its intended purpose of controlling health care costs. Indeed, it may defeat that purpose by interfering with competitive market forces that would otherwise help contain costs. However, should the legislature decide to retain CON regulation, we believe that decreases in the scope of coverage and increases in the threshold for covered services would reduce the negative effects of the CON system.

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[47] For example, freestanding ambulatory surgical centers are a fast-growing, innovative form of treatment whose introduction has been retarded by CON regulation (see Section II.C., *supra*).

[48] LBFC Report at 11.

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,

John M. Mendenhall
Acting Director
Cleveland Regional Office

Enclosed FTC Staff Reports:

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

Competition Among Hospitals (1987); and

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