Certificate of Need Regulation of Health Care Facilities

Prepared Statement of

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Before

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It is a pleasure to be here today to discuss the available evidence on the need for and effectiveness of Certificate of Need, or CON, regulation.[1] My name is Keith Anderson. I am Special Assistant to the Director of the Bureau of Economics of the Federal Trade Commission. For the last ten years, much of my professional work has focused on the effects of government regulation on the functioning of markets.[2] I am a coauthor of one of the three studies the Bureau of Economics has published in the last three years dealing with Certificate of Need regulation.[3]

To promote competition in health care markets, the Federal Trade Commission and its staff have been active both in antitrust law enforcement and in advocacy of regulatory reforms, including advocating the repeal of Certificate of Need regulation in several other states.[4] In addition, many of the Commission's antitrust investigations in the health care field focus on competitive problems that would be less severe if there were no CON regulations.[5]

In these comments, I would like to do four things. First, I would like to review the economic evidence concerning the effectiveness of CON

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

[2] A copy of my vita is attached.

[3] Keith B. Anderson and David I. Kass (1986), *Certificate of Need Regulation of Entry into Home Health Care: A Multi-product Cost Function Analysis*, Bureau of Economics Staff Report to the Federal Trade Commission. The other studies are Monica Noether (1987), *Competition Among Hospitals*, Federal Trade Commission, Bureau of Economics Staff Report; and Daniel Sherman (1988), *The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis*, Bureau of Economics, Federal Trade Commission.

[4] See, *e.g.*, Letter to Maston T. Jacks, Esq., Chairman, Commission on Medical Facilities and Certificate of Public Need, Commonwealth of Virginia, from Jeffrey I. Zuckerman, Director Bureau of Competition, Federal Trade Commission, dated August 6, 1987; Letter to The Honorable John F. Pressman and The Honorable Donald W. Snyder, Pennsylvania State Representatives, from John M. Mendenhall, Acting Director, Cleveland Regional Office, Federal Trade Commission, dated March 30, 1988; Letter to The Honorable Culver Kidd, Georgia State Senator, from Paul K. Davis, Director, Atlanta Regional Office, Federal Trade Commission, dated February 6, 1989; and Letter to The Honorable Bernice Labedz, Nebraska State Senator, from Jeffrey I. Zuckerman, Director Bureau of Competition, Federal Trade Commission, dated February 22, 1988.

[5] See, *e.g.*, Hospital Corporation of America [Chattanooga acquisitions], 106 F.T.C. 361, 489-496 (1985), affirmed 807 F.2d 1381 (7th Cir. 1986), cert. denied, 107 S.Ct. 1975 (1987); Hospital Corporation of America [Forum acquisitions], 106 F.T.C. 298 (1985) (consent order); and American Medical International, 104 F.T.C. 1 (1984).

In these comments, I would like to do four things. First, I would like to review the economic evidence concerning the effectiveness of CON regulation in controlling health care costs. Second, I will consider the effects of CON regulation in limiting competition and innovation in health care markets. Third, I will discuss changes in health care in recent years that have increased the ability of health care markets to function in an unregulated, competitive way. Finally, I will briefly consider some of the rationales for CON regulation.

To jump ahead and provide a preview of my conclusions, almost all of the available empirical evidence suggests that CON regulation does not help control the costs of health care. Further, the staff of the Federal Trade Commission's Bureau of Economics find nothing in the issues that I will discuss that leads us to believe that Certificate of Need regulation is necessary to achieve any of the rationales advanced for it. Consumers would most likely be better served if CON regulation were removed.

A. The Available Economic Evidence Strongly Suggests That Certificate of Need Regulation Has Not Been Effective in Reducing the Costs of Health Care.

As I noted, in the past three years, the Bureau of Economics has published three studies that, in whole or in part, look at the effectiveness of Certificate of Need regulation in reducing the cost of providing health care services. (I believe cost reduction is the primary objective of those advocating CON regulation.) These studies are only three of at least sixteen studies on the effects of CON regulation that have appeared in the economics literature in the last fifteen years.[6] Of these 16 studies, 11

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[6] In addition to the three Bureau of Economics' studies, the following studies have been done: (1) David S. Salkever and T.W. Bice (1976), "The Impact of Certificate of Need Controls on Hospital Investment," *Milbank Memorial Fund Quarterly*, 54 (Spring), pp. 185-214; and (1979) *Hospital Certificate of Need Controls: Impact on Investment, Costs, and Use*, American Enterprise Institute; (2) F.J. Hellinger (1976), "The Effect of Certificate-of-Need Legislation on Hospital Investment," *Inquiry*, 13 (June), pp. 187-193; (3) Frank A. Sloan and Bruce Steinwald (1980a), "Effects of Regulation on Hospital Costs and Input Use," *Journal of Law and Economics*, 23 (April), pp. 81-109;and (1980b) *Insurance, Regulation, and Hospital Costs*, Lexington Books; (4) D.R. Cohodes (1980), *Institutional Response to Regulation: Certificate of Need and Hospitals*, Unpublished PhD Dissertation, Harvard University School of Public Health, January; (5) Policy Analysis, Inc., and Urban Systems Research and Engineering, Inc. (1980), *Evaluation of the Effects of Certificate of Need Programs*, HRA #231-77-0144, Department of Health and Human Services; (6) Craig Coelen and Daniel Sullivan (1981), "An Analysis of the Effects of Prospective Reimbursement Programs on Hospital Expenditures," *Health Care Financing Review*, 2 (Winter), pp. 1-40; (7) Paul L. Joskow (1980), "The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital," *The Bell*

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examine the effect of CON on the cost of health care, while seven examine the effect of these regulations on hospital investment.[7] Rather than examine the Bureau of Economics' studies alone, I would like to summarize the conclusions that follow from all of the studies.

In their 1981 review of five studies of CON regulation, Bruce Steinwald and Frank Sloan, two Vanderbilt University health economists, wrote:

> Research on [certificate of need] hospital regulation has produced remarkably consistent results. The empirical evidence indicates that certificate-of-need laws have not been successful in restraining per diem, per case, or per capita hospital costs.[8]

There has been little evidence in the 10 or so studies that have appeared since the Steinwald and Sloan review to alter the conclusions drawn at that time. There is near total agreement among health economists that Certificate of Need regulation does not achieve the goal of lowering the costs of health care: some studies find costs are the same whether or not CON regulations are present, others find that costs are actually higher where there is CON.[9] The majority of these studies have examined the

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Journal of Economics, 11 (Autumn), pp. 421-447; (8) Frank A. Sloan (1981), "Regulation and the Rising Cost of Hospital Care," *Review of Economics and Statistics*, (November), pp. 479-487; (9) Paul L. Joskow (1981), *Controlling Hospital Costs: The Role of Government Regulation*, MIT Press; (10) Steven Eastaugh (1982), "The Effectiveness of Community-based Hospital Planning: Some Recent Evidence," *Applied Economics*, 14 (October), pp. 475-490; (11) A. Lee, H. Birnbaum, and C. Bishop (1983), "How Nursing Homes Behave: A Multi-Equation Model of Nursing Home Behavior," *Social Science and Medicine*, 17, p. 1897; (12) Dean E. Farley and Joyce V. Kelly (1985), *The Determinants of Hospitals' Financial Positions*, National Center for Health Services Research; and (13) John W. Mayo and Deborah A. McFarland (1989), "Regulation, Market Structure, and Hospital Costs," *Southern Economic Journal*, 55 (January), pp. 559-569. (In some cases, essentially the same study has been published in two different places. These are listed together and are only counted as one study.)

[7] Two of the studies -- Sloan and Steinwald (1980a and 1980b) and Policy Analysis, Inc., and Urban Systems Research and Engineering, Inc. (1980) -- examine the effects of CON regulation on both the costs of hospital care and on hospital investment behavior.

[8] Bruce Steinwald and Frank A. Sloan, "Regulatory Approaches to Hospital Cost Containment: A Synthesis of the Empirical Evidence," in *A New Approach to the Economics of Health Care*, edited by Mancur Olson, American Enterprise Institute, 1981, p. 285.

[9] Supporters of CON regulation sometimes point to the number or dollar amount of projects denied, withdrawn or modified as a result of the (continued...)

effect of CON on hospital services.[10] However, similar results have been

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CON process as an indication of the value of CON regulation. These amounts, however, are not necessarily an accurate measure of the "excessive" capital investment deterred because CON regulation may cause the filing of applications for more projects than would actually be carried out in an unregulated market.

CON regulation may force firms to compete for a limited number of project approvals. Because the projects are approved on a showing of "need", applicants may assume that any CON granted reduces the likelihood that a approval will be granted to another applicant with a similar project. This generates pressure to file preemptively or defensively (particularly under combined review, where applications for similar projects are required to file at the same time). When several applicants seek approval of similar projects in the same area, that does not mean that in the absence of CON regulation all proposed projects would be carried out. The applicants may realize that demand exists for only one project. Therefore, denial of all applications but one would not represent actual savings resulting from the regulations.

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

The anticipation that projects will not be approved may also deter firms from filing for projects they would actually construct in the absence of CON regulation. In this case, the number of applications denied would understate the effectiveness of the CON process. Since the number of applications denied, withdrawn, or modified may either overstate or understate the actual number of projects deterred, this is not a reliable way to measure the effectiveness of the regulations.

[10] Of the nine studies examining the effect of CON on hospital costs, Coelen and Sullivan (1981), Sloan (1981), and Joskow (1981) find that CON has no significant effect on costs. Farley and Kelly (1985), Noether (1987), and Sherman (1988) all found that hospital costs were higher where there was CON regulation. Sloan and Steinwald (1980a and 1980b) found that CON regulation has no significant effect on costs where CON regulation is comprehensive. However, costs were higher in states that only regulated additions to beds than in states that had no CON regulation.

These studies use cost data for various years to examine differences between states with CON regulation and states without it. Further, states have enacted and revised their CON regulations at times. Two of the studies, those of Coelen and Sullivan and Sloan and Steinwald, look for differences in the rate of change in costs between states that have CON and those that do not. Sherman (1988) examines differences in costs associated with different review thresholds -- *i.e.*, with differences in the stringency of the CON regulation. Only one of the studies -- Mayo and McFarland (1989) -- finds that hospital costs are lower where CON regulation is more

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found in studies of nursing homes and of firms providing home health care services.[11]

In addition to the studies that empirically examine the effects of Certificates of Need, one recent study has sought to establish the theoretical relationship between hospital costs and the presence of CON regulation. The author of this study found that, even at a theoretical level, it was not clear that CON regulation could control costs. Whether a perfectly functioning CON program would reduce hospital costs depends crucially on the way in which hospitals are reimbursed and on whether the main effect of CON regulation is to limit expansion of existing hospitals or to keep new hospitals from opening. According to the study, CON should be expected to lead to lower costs per admission in some cases; in others it will lead to higher costs. Interestingly, where hospitals are reimbursed on a per case basis--the method Medicare now uses for hospital operating costs -- CON should be expected to have no effect on costs.[12]

In sum, the economic evidence concerning the effectiveness of CON regulation still supports the 1981 conclusions of Steinwald and Sloan that

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stringent. While no economic study is methodologically perfect, the problems with this study, which are discussed in more detail in footnote 13, seem particularly great.

Several of the studies have examined the effect of Certificate of Need regulation on investment in new hospital assets. Most of the studies appear to find no significant reduction in hospital assets in states that have CON regulation. (See Hellinger (1976), Cohodes (1980), Policy Analysis, Inc., and Urban Systems Engineering, Inc. (1980), and Eastaugh (1982).) However, some of the studies have found that Certificate of Need regulation has limited investment in additional hospital beds. (Salkever and Bice (1976 and 1979) and Joskow (1980)). Others have found that CON has had no effect or has even increased the number of beds. (Sloan and Steinwald (1980a and 1980b)) Even if CON has reduced the growth in new hospital beds, it appears that hospitals have increased their use of other inputs. Salkever and Bice (1976 and 1979) found a substitution toward unregulated forms of capital. While Sloan and Steinwald (1980a and 1980b) did not find a substitution toward unregulated capital, they found that hospitals subject to CON regulation tended to have higher employment levels than comparable unregulated hospitals.

[11] Lee, Birnbaum, and Bishop (1983) found that nursing home costs were higher in states with CON regulation, while Anderson and Kass (1986) found that Certificate of Need regulation did not appear to increase the attainment of economies of scale in home health care services and also that CON regulation was associated with higher per unit costs.

[12] Peter C. Coyte, "Alternative Methods of Reimbursing Hospitals, and the Impact of Certificate-of-Need and Rate Regulation for the Hospital Sector," *Southern Economic Journal*, 53 (April 1987), pp. 853-873.

"[C]ertificate-of-need controls . . . may be regarded as a classic example of regulatory failure."[13]

Why have Certificate of Need regulations been ineffective? To answer this question we must understand that the key justification for CON legislation was the belief that hospitals did not have the proper incentives to control their costs. Patients did not directly pay for most of their health care -- particularly hospital care. The costs were paid by private insurance companies or by the government. In addition, in most cases, payment was on a retrospective cost reimbursement basis: the amount the hospital received was determined by the costs incurred in treating the particular patient. As a result, proponents of planning argued, patients would not be sufficiently sensitive to high prices; and competition among hospitals would focus on patients' perceptions of quality and convenience. Further, it was argued that hospitals would compete for patients by competing for physicians, who would be attracted to the hospital that had the fanciest and most modern facilities.[14]

CON regulation may be ineffective because it does not change any of these incentives. Hospitals are no more likely to compete on the basis of price with CON regulation than without. CON regulation may affect quality competition among hospitals by foreclosing certain avenues hospitals could

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[13] Steinwald and Sloan (1981), p. 296. As noted before, only the Mayo and McFarland (1989) study finds CON regulation has been effective in reducing hospital costs. However, there are a number of problems with this study which suggest that its findings are unreliable. First, because of the way the authors model the effect of CON regulation, CON is assumed to affect only the number of beds in a hospital. Their approach rules out the possibility that other forms of equipment are substituted for beds or that additional staff is substituted for capital equipment where there is CON regulation. As noted in footnote 10, several studies have found that these kinds of substitutions occur. Second, as its measure of the stringency of CON regulation the study uses a function of the percentage of applications approved. As discussed in footnote 9, the number of applications approved or denied is not an appropriate measure of the effectiveness of CON regulation. Third, rather than compare costs in states with and without CON regulation or across states with different cost thresholds, this study examines costs in different parts of a single state -- Tennessee. However, CON decisions are made at the state level. Thus, there are no real differences in CON stringency in the data. Finally, the authors use data for the period 1980 through 1984. During this period, hospital utilization rates fell considerably, in part because Medicare introduced a prospective reimbursement system (see pp. 12-13) The authors do not account for these changes in an appropriate way in estimating the costs of hospital care.

[14] See, *e.g.*, Joskow (1981), pp. 21-31. See also Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-99, Section 103 (b), 93 Stat. 592 (1979), repealed, Publ. L. No. 99-660, Section 701(a), 100 Stat. 3799 (1986) and the Findings of Fact contained in the North Carolina Certificate of Need Statute (N.C. Gen. Stat. Section 131E-175 (1)).

use to achieve their goals. However, it does not eliminate any incentives to be extravagant. In some cases, existing hospitals may have been able, perhaps with a delay, to obtain approval for arguably uneconomic projects even with CON regulation. Other hospitals were able, the evidence suggests, to find new ways to compete. For example, if the CON law only required approval for some kinds of capital investments -- *e.g.*, new beds -- the hospitals could add other kinds of fancy equipment. If all equipment was covered, hospitals could compete by providing additional staff.[15] Thus, CON regulation did not lower costs by ending supposedly unnecessary expenditures, it merely redirected such expenditures into other areas.

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

The foregoing discussion suggests that CON regulation has been ineffective. But more than that, these regulations have probably been harmful. The CON regulatory process may increase prices to consumers by protecting health care providers from competition by new entrants.[16] CON also reduces the possibility of entry by firms that could provide services of higher quality or lower cost than existing firms, and that could perhaps replace providers that are not effectively meeting consumer needs. This may explain why several of the studies I reviewed today found that costs were higher in states with CON regulation.

Because Certificate of Need regulation delays or reduces the prospect of new entry and expansion,[17] it increases the likelihood that providers will

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[15] Salkever and Bice (1976 and 1979) found a substitution toward unregulated forms of capital. While Sloan and Steinwald (1980a and 1980b) did not find a substitution toward unregulated capital, they found that hospitals subject to CON regulation tended to have higher employment levels than comparable unregulated hospitals.

[16] Richard A. Posner (1974), "Certificates of Need for Health Care Facilities: A Dissenting View," in *Regulating Health Facilities Construction*, edited by Clark Havighurst, American Enterprise Institute, pp. 113-117.

[17] The CON process generally places the burden on the applicant to demonstrate that a need is not being served by those currently in the market. For example, N.C. Gen. Stat. Section 131E-183 (a)(3) states: "The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed . . . ." (emphasis added) Similarly, N.C. Gen. Stat. Section 131E-183 (a)(6) states: "The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities."

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. For example, an evaluation of the CON program in

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exploit whatever market power they have, individually or collectively, to raise prices above, or reduce quality below, the competitive level. That is why the Federal Trade Commission has cited the entry barrier created by CON regulation as a factor significantly contributing to the potential for anticompetitive effects from hospital mergers.[18]

To the extent that CON regulation reduces the supply of particular health services below competitive levels, prices for these services can be expected to be higher than they would be in an unregulated market.[19]

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Michigan found that the number and complexity of CON appeals increased dramatically from 1979 to 1986, and comparative reviews were particularly protracted. (Michigan Statewide Health Coordinating Council, *An Evaluation of the Certificate of Need Program*, March 1987, pp. 29-34) See also, Hospital Corporation of America [Chattanooga acquisitions], 160 F.T.C. at 490-92. CON regulation may also create opportunities for existing firms to abuse the regulatory process to prevent or delay new competition. (Terry Calvani and Neil Averitt (1987), "The Federal Trade Commission and Competition in the Delivery of Health Care," *Cumberland Law Review*, 17, p. 283 (discussing potential for health providers to use CON process for "non-price predation"); St. Joseph's Hospital v. Hospital Corporation 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 Corporation of America [Chattanooga acquisitions], 106 F.T.C. at 492.)

[18] American Medical International, 104 F.T.C. at 200-201 (1984); Hospital Corporation of America [Chattanooga acquisitions], 106 F.T.C. at 489-496. In affirming the Commission's decision in Hospital Corporation of America, Judge Posner agreed that CON regulation can create a barrier to entry. (Hospital Corporation of America v. Federal Trade Commission, 807 F.2d. 1381, 1387 (7th Circuit, 1987))

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

[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 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

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Curtailing services or facilities may force some consumers to resort to more expensive or less-desirable substitutes, thus increasing costs for third-party payers or patients. For example, if nursing home beds are not available, the discharge of patients from more expensive hospital beds may be delayed[20] or patients may be forced to use nursing homes far from home.

CON regulation may also interfere with competition by delaying the introduction and acceptance of innovative alternatives to costly treatment methods. Regulators may lack the information to determine how many such facilities are needed, or they may not respond rapidly enough to changing market conditions. It is difficult to predict demand for innovations in medical practice.[21] Providers have strong financial incentives, which health-planning agencies lack, to gather information and to adjust to unexpected changes in costs or demand. Thus, reliance on market forces is likely to provide more rapid and desirable responses to changing conditions than CON regulation.

C. Health Care Markets Are Now More Able to Function Effectively Without Certificate of Need Regulation.

As I noted, CON regulation was imposed in the belief that consumers lacked strong incentives to seek out lower cost health care and that providers, therefore, did not have sufficient incentives to keep their costs down. But, CON regulation has not successfully reduced health care costs because it does not affect those incentives. However, recent changes in health care markets that do alter incentives should increase the likelihood that unregulated competition will provide health care services efficiently.

Private and public insurance still pays for the vast majority of health

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elsewhere. (See J. Feder and W. Scanlon (1980), "Regulating the Bed Supply in Nursing Homes," *Milbank Memorial Fund Quarterly*, 58, p. 76.)

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

[21] Freestanding ambulatory surgical centers (FASCs) offer an innovative, less costly alternative to hospital surgical facilities. However, evidence suggests that the growth of FASCs generally has been hampered by the CON process. (Dan Ermann and Jon Gabel (1985), "The Changing Face of American Health Care," *Medical Care*, p. 407) In addition, action on all CON applications for FASCs in Pennsylvania was delayed by six months while a CON task force reviewed the need for these facilities. (Budget and Finance Committee of the Pennsylvania Legislature, *Report on a Study of Pennsylvania's Certificate of Need Program*, February 1987, p. 14.)

care.[22] This is particularly true of hospitalization, where only 9.4 percent of costs were paid directly by consumers in 1986.[23] However, consumers and employers have become more sensitive to the costs of health insurance and have therefore sought ways to increase incentives for health care providers to behave efficiently.

One indication of this increased attention to cost control is the growth in health maintenance organizations (HMOs) and preferred provider organizations (PPOs). By 1988, HMO enrollment was 31.4 million.[24] This represented more than a five-fold increase from the 6.0 million enrolled in 1976.[25] Today, an estimated total of 45 to 50 million people have the option of using a preferred provider.[26] In December 1984, only 1.3 million were enrolled in plans with a PPO option.[27]

Another recent change in health insurance has been the tendency for companies to self-insure. By 1987, about 60 percent of employers were self-insuring in whole or in part.[28] According to one source, these employers are increasingly interested in competitive alternatives to further reduce their health costs.[29]

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[22] Direct payments by consumers accounted for 28.7 percent of total personal health care expenditures in 1986, the same level found in 1980. (*Health, United States, 1987*, table 102, p. 158)

[23] *Health, United States, 1987*, table 103, p. 159. This represents a slight increase from 1977, when only 6 percent of hospital expenditures were paid directly by consumers. (Paul Feldstein (1979), *Health Care Economics*, John Wiley and Sons, p. 32.)

[24] As of June 1988, there were 643 HMOs in the United States. (Telephone interview with David Glazer of InterStudy, February 10, 1989.)

[25] *Health, United States, 1987*, table 112, p. 170.

[26] There are currently 637 PPOs in operation in the U.S. (Telephone interview with Ed Pickens, American Medical Care and Review, February 10, 1989.)

[27] Jon Gabel, Dan Ermann, Thomas Rice, and Gregory de Lissovoy, "The Emergence and Future of PPOs," *Journal of Health Politics, Policy and Law*, 11 (Summer), p. 306.

[28] Based on data in Steven DiCarlo and Jon Gabel (1988), "Conventional Health Plans: A Decade Later," Research Bulletin, Health Insurance Association of America, p. 11. Before 1975, less than 10 percent of health insurance premiums went into self-insured plans. (Jeff Goldsmith (1984), "Death of a Paradigm: The Challenge of Competition, *Health Affairs*, 3 (Fall), p. 9)

[29] Goldsmith (1984), pp. 9-10.

The percentage of firms requiring reviews before a patient is admitted to a hospital and requiring second opinions prior to surgery has also increased. By 1987, preadmission certification was required by over one-third of company-offered health plans,[30] compared with 2 percent in 1982.[31] In 1987, more than 40 percent of employee health plans mandated a second opinion prior to surgery,[32] while only 28 percent of plans did so in 1984.[33] Finally, the use of copayments and deductibles in private health insurance plans has increased.[34] These changes increase incentives for consumers to purchase less expensive health care and forego unnecessary treatments.[35]

Government-funded programs have also introduced changes. The Medicare system has converted payment of hospital operating costs to a prospective payment approach, in which standardized payments are based on the patient's diagnosis, rather than on the costs incurred in each individual case.[36] In addition, many states have been experimenting with cost

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[30] DiCarlo Gabel (1988), p. 11.

[31] Goldsmith (1984), p. 14.

[32] DiCarlo and Gabel (1988), p. 11. Moreover, an additional 10 percent required a second opinion in some cases.

[33] Goldsmith (1984), p. 14.

[34] Between 1982 and 1984, the percentage of insurance plans paying 100 percent of hospital charges for the first days of hospital care fell from 67 percent to 42 percent. The percentage paying 100 percent of surgical fees fell from 42 percent to 26 percent. In 1982, only 4 percent of plans required an annual deductible of $200 or more per family. (Goldsmith (1984), p. 12) By 1987, the average plan had an deductible of $330. (Computed from figures in DiCarlo and Gabel (1988), p. 14.)

[35] A recent Rand Corporation study funded by the Department of Health and Human Services demonstrated that consumers demand less health care when they have to pay a higher portion of the cost of that care. (Willard G. Manning, Joseph P. Newhouse, Naihua Duan, Emmett B. Keeler, Arleen Leibowitz, and M. Susan Marquis (1987), "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review*, 77 (June), pp. 251-277)

[36] In contrast to operating cost reimbursement, prospective reimbursement for the capital costs of hospital care has been delayed until at least 1991. (See 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 of prospective reimbursement for capital-related costs until 1991.) As a result, it is difficult to predict the effect of Medicare prospective reimbursement on hospital investment activity. However, there are several reasons to believe that changes in Medicare reimbursement already made and those proposed will pressure hospitals to

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containment strategies for their Medicaid programs. Several states have begun using HMOs or other capitation and case-management strategies to provide care to Medicaid patients.[37] In addition, some states have used prospective reimbursement plans to pay for nursing home costs.[38]

These changes have had substantial effects on the demand for health care. Between 1975 and 1986, hospital usage rates declined more than one-

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reduce any unnecessary investment even today. First, the costs of any major capital investment programs undertaken now will have to be recovered in hospital charges long past 1991. Therefore, current investment plans will be substantially affected by any anticipated changes in reimbursement for capital costs in 1991. Second, some studies have found that increases in hospital capital investment result in increases in hospital operating expenses. (See Gerard Anderson and Paul B. Ginsberg (1984), "Medicare Payment and Hospital Capital: Future Policy Options," *Health Affairs*, 3 (Fall), p. 37, citing a 1982 study by Arthur D. Little, Co., "Development of an Evaluation Methodology for Use in Assessing Data Available to the Certificate of Need (CON) and Health Planning Problems," Office of the Assistant Secretary for Health, Department of Health and Human Services, Contract No. 233-79-4003) Thus, existing restraints on operating expense reimbursement may restrain capital spending as well. Finally, there have been substantial declines in hospital admissions and average length of stay for Medicare patients since the prospective reimbursement system was put in place. During the first three years of the program, total Medicare admissions fell by 11.3 percent, and admissions per Medicare enrollee fell by 15.9 percent. During the same period, the average length of stay for Medicare enrollee fell 17 percent (Stuart Guterman, Paul W. Eggers, Gerald Riley, Timothy F. Greene, and Sherry A. Terrell (1988), "The First 3 Years of Medicare Prospective Payment: An Overview," *Health Care Financing Review*, 9 (Spring), pp. 68-69). Such a significant reduction in hospital utilization is likely to make it more difficult for hospitals to justify new capital expenditures.

[37] Under a capitation plan, a provider receives a fixed payment per month which depends on the number of covered patients who select that firm or individual as their primary care provider. This payment is independent of the costs of any care provided to any particular patient. In some cases, states have used partial capitation plans where the provider receives a fixed fee to cover some set of basic services. However, additional payments are made if the patient needs care not covered under the capitation agreement. (Deborah A. Freund and Edward Neuschler (1986), "Overview of Medicaid Capitation and Case-Management Initiatives," *Health Care Financing Review*, (Annual Supplement), pp. 21-30)

[38] James H. Swan, Charlene Harrington, and Leslie A. Grant (1988), "State Medicaid Reimbursement of Nursing Homes, 1978-86," *Health Care Financing Review*, 9 (Spring), pp. 33-50.

third.[39] While some of this decline was probably the result of technological change in health care, economic incentives also appear to have played an important role. Before Medicare introduced its prospective reimbursement system, hospitalization rates declined more slowly for senior citizens than for younger patients. Since 1983, when prospective reimbursement was introduced, senior citizen usage has declined at 8.3 percent per year, the same rate as for the population at large.[40]

As consumers and health insurers become more cost-conscious, hospitals with inflated costs and prices will increasingly risk losing business. This is particularly true where HMOs and PPOs can direct their large numbers of patients to hospitals that charge lower fees. Thus, the growing cost sensitivity of consumers and health insurers should increase incentives for hospitals to provide quality service at the lowest possible price.

D. Other Arguments in Favor of Certificate of Need Regulation Do Not Support Such Interference With the Competitive Market.

Several other rationales for Certificate of Need frequently crop up. I would briefly like to comment on three: (1) that CON regulation is necessary to assure quality health care; (2) that state taxpayers will face higher costs to provide hospital care for the poor if CON regulation is eliminated; and (3) that the State's Medicaid costs for nursing home care will increase if CON regulation is ended.

1. CON regulation is not necessary to assure quality in the provision of health care.

States often suggest that assuring quality is one of their reasons for enacting Certificate of Need legislation.[41] However, CON does not appear to be effective in assuring quality. A Certificate of Need review occurs only when a hospital or other health care facility wishes to make an investment

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[39] In 1975, the rate of hospital utilization was 1,254.9 days of care per 1,000 persons. (National Center for Health Statistics, *Health, United States, 1978*, DHEW Publication No. (PHS) 78-1232, Public Health Service, U.S. Government Printing Office, 1978, table 101, p. 308) In 1986, the rate was only 833.1 days of care per 1,000 persons. (*Health, United States, 1987*, table 63, p. 109.

[40] Between 1975 and 1980, hospital use by persons aged 65 and above declined at a rate of 0.33 percent per year. For the population as a whole, the rate of decline was 1.98 percent. Between 1980 and 1983, the rate of decline was 0.77 percent per year for seniors and 2.05 percent for the population as a whole. (Based on data in *Health, United States, 1978*, table 101, p. 308, and *Health, United States, 1987*, table 63, p. 109.)

[41] See, *e.g.*, James B. Simpson (1986), "Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control," *Indiana Law Review*, 19, pp. 1028-1030.

that requires CON approval. Thus, the CON process cannot be used to discipline an institution that is providing an unacceptable quality of care unless the institution is regularly applying for new project approvals. On the other hand, periodic accreditation and licensing reviews provide a way to monitor quality on an ongoing basis. These mechanisms are probably sufficient to ensure quality. CON regulation appears both unnecessary and largely ineffective as a means of quality control.[42]

2. Eliminating CON regulation will not increase the costs of providing hospital care to the poor.

While the cost of indigent care is frequently cited in debates on Certificate of Need,[43] the relation to CON regulation is unclear. One possibility is that, absent competition, hospitals can charge paying patients rates high enough to cover the unreimbursed costs of indigent care.[44]

If this is occurring, several observations would appear to be in order. First, such a system may not be able to survive, even with CON regulation, as cost-conscious private insurers and governments pressure providers to operate more efficiently. For example, hospitals not subsidizing care for the poor with higher rates to paying patients will be more successful in competing for patients.

Second, hospital rates that cover the cost of subsidizing care for the poor constitute an indirect tax on paying users of hospital services and on all holders of private health insurance. While this "tax" is not paid directly to the government, in its effect, it is as much a tax as a direct levy on

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[42] The CON quality assurance role is sometimes justified by pointing to epidemiological studies that show that hospitals that perform certain operations more frequently have lower mortality rates from those operations. (See, *e.g.*, Simpson (1986), p. 1030.) However, accreditation and licensing should be able to assure that adequate levels of quality are maintained here as well. If a certain volume is necessary to assure quality in certain surgical procedures, a hospital could be granted only a provisional license or accreditation to perform that operation. To be fully-licensed or accredited, the hospital would have to demonstrate that it is generating enough of patients to assure quality. If, after some period of time, the hospital is not meeting this requirement, the license or accreditation to perform that service would be withdrawn. One advantage such an approach would have over the CON process is that a hospital which can offer the service at a higher quality level or a lower cost would be able to enter and compete with existing providers. This is much more difficult, if it is possible at all, with a CON process.

[43] See, *e.g.*, M. Lerner, et al. (1987), *Investigation of Certain Issues in Connection With the Virginia Certificate of Need Law*, in which one of the questions asked of all parties expressing opinions on CON repeal was how repeal would affect the provision of medical care for the indigent.

[44] This argument is suggested in Lerner, et al. (1987), p. VII.22.

hospital services or health insurance premiums.[45] In either case, the consumer -- *i.e.*, the taxpayer -- pays a price that exceeds the value of the service provided. Furthermore, the costs of the current system are probably greater than would be necessary if an alternative tax was imposed to pay for indigent care.[46]

Third, any such indirect tax is highly regressive. The costs of health care and of health insurance are no lower for low income families and individuals than for the well-to-do.[47] Thus, low income families spend a higher percentage of their income on health insurance and health care.[48]

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[45] Several states, including Florida, Wisconsin, South Carolina, and New York have developed procedures under which funding for indigent health care is financed from taxes on hospital revenues. (See M. Lerner, et al., (1987), p. VII.24, n. *) We take no position on whether a tax on hospital revenues or on health insurance premiums is superior to other alternatives such as funding indigent care from general tax revenues.

[46] There are two reasons for this. First, as noted above, the CON process probably inhibits competition and slows innovation. This is apt to result in higher costs, lower quality, or both. This inefficient provision of services would be eliminated *if* CON was repealed and an alternative means found *to fund* indigent care. Second, if CON regulation limits entry of new health facilities for the purpose of guaranteeing prices high enough to cover the costs of indigent care, the actual payments to health facilities, in aggregate, are likely to be more than is necessary to do so - even if the facilities behave competitively in pricing their health services. This occurs when existing facilities differ in their burden of indigent care. If prices are high enough to cover the costs of indigent care at a facility with the highest percentage of indigent patients, the same prices will be more than adequate to cover indigent care costs at the facility with the lowest percentage of indigent patients. Thus, while indigent care costs are "covered" at all facilities, the aggregate of payments by non-indigent patients *will* be in excess of the minimum necessary to cover indigent care needs. In this case, use of tax money to subsidize indigent care, coupled with the competitive benefits of eliminating CON limitations on entry, may result in lower costs of subsidizing indigent care.

[47] If anything, families with lower incomes tend to need more health care. In 1986, families with incomes below $10,000 had an average of 6.6 visits to a physician. For all income classes above $10,000, the average number of visits was either 5.3 or 5.4 (*Health, United States, 1987*, table 57, p. 103) Hospital care is even more strongly related to income: In 1986, families with incomes less than $10,000 had 1,445.9 days of hospitalization per 1,000 population. The hospitalization rate fell steadily as income rose. For families with incomes above $35,000, the hospitalization rate was 773.8 days of per 1,000 population. (*Health, United States, 1987*, table 62, p. 108.)

[48] See, *e.g.*, Alain Enthoven and Richard Kronick (1989), "A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System

(continued...)

3. Eliminating CON regulation need not lead to increases in expenditures for nursing home beds under the State's Medicaid program.

Turning now to the third argument, states also appear to have used CON to control the number of nursing home beds for which they must pay under the Medicaid program.[49] Thus, it is feared that CON repeal will be accompanied by large, uncontrollable increases in the Medicaid budget.[50] The concern appears to be, not with the cost per bed, but rather with the absolute number of beds.[51]

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[48](...continued)
Designed to Promote Quality and Economy," *The New England Journal of Medicine*, 320 (January 12), p. 95.

[49] See, *e.g.*, Simpson (1986), p. 1032.

[50] M. Lerner, et al. (1987), VII.24.

[51] As I noted above, the one study that has examined the effect of CON regulation on the cost of nursing home care found that per unit costs were higher in states with CON regulation. (Lee, Birnbaum, and Bishop (1983))

The experience in two of the states that first ended CON regulation of new nursing home bed construction would appear to provide some support for this expectation: in both Arizona and Utah, deregulation was accompanied by large increases in the number of nursing home beds. Arizona repealed its CON regulation of new nursing home bed construction in July 1982. (Lerner, et al. (1987), p. VI.12) The number of skilled nursing facility and intermediate care facility beds in Arizona grew from 7,148 in 1982 to 13,734 in 1986 -- an annual rate of growth of 16.3 percent. (Charlene Harrington, James H. Swan, and Leslie A. Grant (1988), "Nursing Home Bed Capacity in the States, 1978-1986," *Health Care Financing Review*, 9 (Summer), p. 87) Utah repealed all of its CON requirements in December 1984. (Lerner, et al. (1987), p. VI.12) In 1984, there were 5,425 nursing home beds in Utah. (Harrington, Swan, and Grant (1988), p. 87) By 1988, the number had increased to 6,906 -- a 27.3 percent increase over four years. (Telephone interview with John Williams, Office of Health Facilities and Licensure, Department of Health, State of Utah, January 27, 1989)

However, on closer inspection, it is not clear that the experience in Utah and Arizona would be repeated in other states. Prior to deregulation, both states had a ratio of nursing home beds to population aged 65 and above that was below the average for the nation as a whole. Arizona, with 21 beds per 1,000 aged citizens, had the lowest bed rate of any state in the nation. By 1986, the ratio in Arizona had only risen to 33.5, the fifth lowest ratio among the states. Utah had 42.4 beds per 1000 aged in 1984, compared with a national average of 51.9 beds per 1000 aged. (Harrington, Swan, and Grant (1988), p. 89) Thus, it is possible that the construction of new beds in Arizona and Utah merely represented a catching up with demand that would not be repeated in other states.

States may well be interested in limiting their Medicaid expenditures and may, therefore, conclude that they will limit the number of nursing home beds for which state Medicaid funds will pay. The Federal Trade Commission's Bureau of Economics has no expertise here; and therefore we cannot advise the State of North Carolina on how many beds should be available for Medicaid patients. However, if the state chooses to impose such a limit, we would point out that Certificate of Need regulation would not appear to be the best way of doing so.

If CON regulation is used, the number of nursing home beds available to everyone is restricted. As a result, citizens paying for their own use of nursing homes, or those having private nursing home insurance, may have more difficulty finding the service and quality levels they desire.[52] Further, as a result of CON entry restrictions, such patients will likely pay higher prices than they would if the market were allowed to function competitively.[53]

Moreover, if CON regulation is used to limit the number of beds for which Medicaid must pay, it is not clear that the state will pay the lowest possible cost for the use of those beds. Indeed, the one study examining nursing home costs and Certificate of Need found that costs were higher in regulated states.[54]

There are alternative mechanisms for limiting the number of nursing home beds for which Medicaid reimburses. One approach would be to control the maximum rate the state pays nursing homes for care of Medicaid patients.[55] Another approach would be to directly limit the number of beds

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[52] In 1987, 51 percent of nursing home care was paid for by those receiving the care or their families. Private health insurance paid for 0.8 percent of care, while government programs, including Medicare and Medicaid, paid for 47.5 percent of care. (The remainder apparently came from philanthropy or care for which the provider received no reimbursement.) (*Health, United States, 1987*, table 103, p. 159)

[53] Nursing home costs have been found to be higher in states with CON regulation. (Lee, Birnbaum, and Bishop (1983), p. 1903) In addition, the rates charged private-pay patients may well be higher in states with CON regulation, either because the regulations reduce competitive supply or because nursing homes will be able to exercise market power because CON regulation reduces the likelihood of entry.

[54] Lee, Birnbaum, and Bishop (1983), p. 1903.

[55] North Carolina currently uses a prospective reimbursement scheme for Medicaid nursing home beds under which each home is reimbursed at an individually-determined rate -- provided that rate is not above an industry-wide maximum rate. (Telephone interview with Jim Barnhill, North Carolina Division of Medical Assistance, February 16, 1989.) One way to limit the number of nursing home beds filled by Medicaid patients would be to keep the industry maximum reimbursement rate low.

covered by Medicaid. A third alternative would be to rely on utilization reviews to limit nursing home care to those Medicaid patients who truly need care.[56]

In short, the state may choose to impose some form of regulation affecting Medicaid patients. However, CON regulation does not appear necessary to any effort to limit Medicaid expenditures. Further, CON regulation is undesirable because it is likely to limit access for self-paying and privately insured patients, as well as for those on Medicaid.

E. Conclusion

In conclusion, the available economic evidence does not support the view that Certificate of Need regulation reduces the costs of providing health care services. Indeed, it seems more likely that CON regulation increases costs by inhibiting competition and the entry of more efficient or innovative health care providers. In addition, changes in the organization of health care and in health insurance have improved the ability of health care markets to function in an unregulated, competitive environment. Finally, CON regulation does not appear to be an efficient way to ensure the quality of health care services, to assure that health care is available to the indigent, or to control Medicaid expenditures for nursing home beds.

This completes my prepared comments. I thank you for your time and would be happy to attempt to answer any questions you may have.

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[56] Under federal regulations, there must be a utilization review of patients in skilled nursing facilities at the first scheduled meeting after a patient is admitted. That patient must then be reviewed after 30 days and after an additional 60 days. After that there is a review every 90 days. For patients in intermediate care facilities, reviews are required every 180 days. While a utilization review is not required at admission, in North Carolina, there is a review of the patient's need for that type of care prior to admission. (Telephone interview with Olivia Hill, North Carolina Division of Medical Assistance, February 15, 1989)

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