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BUREAU OF COMPETITION

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Chairman
Commission on Medical Facilities
Certificate of Public Need
Commonwealth of Virginia
Richmond, Virginia

Dear Mr. Jacks:

The staff of the Federal Trade Commission 1/ is pleased to respond to your invitation to assist the Commission on Medical Care Facilities Certificate of Public Need ("COPN Commission") in preparing its recommendations to Governor Gerald L. Baliles for reforms of certificate of public need regulation of health facilities ("CON regulation"). For reasons discussed in greater detail below, we believe that CON regulation is unlikely to benefit health care consumers in Virginia, and we support the complete elimination of CON regulation. Ongoing improvements in health care financing are resolving the principal problems that prompted CON regulation, and it is unlikely that CON regulation can help to address any remaining problems. Moreover, any potential benefits of CON regulation are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, CON regulation is likely to harm consumers on balance by increasing the price, and decreasing the quality, of health services in Virginia. We also believe that specific concerns relating to the nursing home industry, and access to health care facilities in some rural and inner-city areas of Virginia, do not warrant retaining CON regulation.

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

1/ These comments represent the views of the Federal Trade Commission's Bureaus of Competition, Consumer Protection, and Economics, and not necessarily those of the Commission itself. The Commission has, however, voted to authorize the staff to submit these comments to you.

regulation, the Commission's staff has gained considerable experience with the economics of health care competition, and with how 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

Market forces generally allocate society's resources far better than decisions of government planners, and should be allowed to operate absent a strong showing that significant market failures make it possible for planners to outperform the market. We believe that such a showing can no longer be made for CON regulation in Virginia.

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

CON regulation of health facilities has been justified principally on the theory that unregulated competition would result in the construction of unnecessary facilities, unnecessary expansion of existing facilities, or unnecessary capital expenditures by health facilities. The assumption underlying this theory was that health facilities had an inherent tendency to expand or purchase unnecessary equipment. It was thought that this tendency was not sufficiently constrained by market forces because most consumers of health care were insured by policies that required little or no out-of-pocket payment, making consumers generally insensitive to the price of health care services. Moreover, health facilities were often reimbursed by third-party payors on a retrospective cost basis, removing whatever incentive they might have had to contain costs.

As a result of these forces, competition among health care facilities was typically based on the quality rather than the

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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); 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 two FTC staff reports are enclosed with this letter.

3/ See Section II.C. below.

price of their services, although limited price competition existed. Health facilities had incentives to expend resources to provide wider ranges of diagnostic and therapeutic services and equipment, and more comfortable facilities. 4/ The concern expressed by health planners when CON regulation was created was that the cost of these improved, albeit underutilized, 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 were built when they otherwise would not be; rather, it was to control the perceived tendency to provide facilities or services that were not needed. 5/

Many of these assumptions supporting CON regulation are no longer valid, in light of substantial changes in health care markets. This is particularly true for general acute care hospital markets, although similar trends are also affecting other health facility markets subject to CON regulation in Virginia.

Third-party payors and consumers have shown increasing sensitivity to the prices of hospital services. There has, accordingly, been a trend toward increased price competition among hospitals. 6/ For example, price competition can be stimulated by health maintenance organizations and preferred provider organizations, which are well-positioned to channel subscribers to hospitals offering quality care at economical rates through selective contracting. These organizations are common in Virginia's major metropolitan areas. Improvements in conventional health benefit programs also provide their subscribers with financial incentives (such as co-payment requirements) that channel them toward economical providers, including non-hospital 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 demands.

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

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

6/ 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.

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).

This effect will be reinforced by the implementation of hospital reimbursement at rates not linked to individual hospitals' costs or charges, such as Medicare's "prospective reimbursement" system. 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. Medicare plans to begin reimbursing capital costs in a somewhat similar manner. 8/ As that system, and others like it, are implemented, the costs of hospitals' inefficiencies will increasingly come out of the hospitals' own pockets rather than those of third party payors and individual consumers.

Moreover, the prospects of further reforms in hospital reimbursement (including the full implementation of improvements already in progress, such as Medicare prospective payment), and of increasingly intense price competition, reinforces the effect of cost-containment incentives already in place. Hospitals should be deterred from making major capital improvements with long useful lives (such as new buildings), if the feasibility of those projects depends on the hospitals' ability to pass the depreciation costs on to third-party payors even if the improvements prove not to have been worthwhile. 9/

These improvements in hospital markets have been accompanied by similar improvements in other markets currently subject to CON regulation in Virginia. For example, reimbursement of nursing homes in Virginia by Medicaid, the dominant third-party payor for

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8/ 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 Modern Healthcare, July 17, 1987, at 10 (House subcommittee approved plan to delay for four years implementation of prospective rates for capital costs).

9/ 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).

nursing home services 10/, now provides significant incentives for cost containment, particularly with respect to the construction of new capacity. Most notably, the Medicaid program flatly 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 keep their capacity fully utilized. 11/ Moreover, price competition for nursing home patients who pay for their care from their own funds 12/ makes it difficult for nursing homes to impose excessive costs upon those patients. Similarly, price competition and/or well-structured governmental and private reimbursement programs limit incentives for overinvestment and other wasteful expenditures for at least some of the other types of health facilities subject to CON regulation in Virginia. 13/

10/ See minutes of April 13, 1987 COPN Commission meeting (presentation of P. Clendenin, director, Virginia Health Care Ass'n) (about 66% of patients in Virginia nursing homes are covered by Medicaid).

11/ Virginia Dep't of Medical Assistance Services, Nursing Home Payment System, VR 460-03-4.194 §§ 2.1-2.9 (1986). As we understand it, Virginia 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 95% 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 5% of total capacity. (Virginia Medicaid also imposes ceilings on reimbursable operating costs of nursing homes, and awards incentive payments to nursing homes with operating costs below the ceilings.)

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

13/ 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)).

B. CON Regulation Is Ineffective as a Cost-Containment Mechanism

It is far from clear that CON regulation effectively restrains whatever tendencies may still exist for inefficient capacity additions or other capital expenditures in Virginia health care markets. A number of empirical studies suggest that CON regulation has not had the intended effect of controlling general acute care hospital costs through the prevention of expenditures on unnecessary beds, services, and equipment. 14/ Early studies of the effects of CON regulation found that it had no effect on constraining overall hospital costs; rather, it may have simply caused hospitals to reallocate their resources so that while some types of hospital costs were constrained by CON regulation, other costs increased. 15/ Later studies reached similar conclusions, finding that CON regulation did not reduce costs per unit of hospital output. 16/ Among these studies are a recent FTC staff report concluding that CON regulation was associated with increases in hospital costs. 17/ Also consistent with these results are preliminary findings of a study sponsored by the COPN Commission and conducted by analysts at Johns Hopkins University,

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14/ 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). (Home health care is not subject to CON regulation in Virginia.) We are not aware of any published empirical analyses focusing on the effectiveness of CON regulation with respect to health facilities other than general hospitals and home health care agencies. However, one study of the economic behavior of nursing homes noted that CON regulation appeared to increase, rather than decrease, the average cost of nursing home services. A. Lee, H. Birnbaum & C. Bishop, supra note 12, at 1906. In addition, preliminary findings of a study sponsored by the COPN Commission address the impact of CON regulation with respect to non-hospital facilities, as discussed below.

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

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

17/ M. Noether, supra note 2, at 74, 82.

indicating "the absence of any clear regulatory effects" of CON regulation on the costs of health facilities in general, including non-hospital facilities. 18/

C. CON Regulation Interferes with Competition in Health Care Markets

Moreover, it is likely that CON regulation is, on balance, 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. 19/ Such artificial shortages of services may sometimes also force consumers to resort to more expensive or otherwise less desirable substitutes, thus also increasing costs for third-party payors 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 20/, or can force patients either

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18/ M. Lerner, et al., Investigation of Certain Issues in Connection With the Virginia Certificate of Need Law, at III-11 (preliminary report, July 13, 1987) [hereinafter "Johns Hopkins Preliminary Report"].

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 providing substandard service to consumers not only from competitive pressures to upgrade performance, but also from regulatory pressures to adhere to licensure requirements. For example, it can be difficult to close a nursing home for major violations of licensure requirements if there is no place to put its patients. See J. Feder & W. Scanlon, Regulating the Bed Supply in Nursing Homes, 58 Milbank Mem. Fund Q. 54, 76 (1980).

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

to use nursing homes far from home 21/, or simply to do without the service altogether.

Even if it does not yield acute shortages of services, CON regulation can substantially interfere with competition in health care markets. First, the CON regulatory process can increase prices to consumers by protecting firms in the market from competition from innovators and new entrants. 22/ Although the CON process does not always prohibit the entry or expansion of health facility enterprises, or the development of new services, it generally places the burden on new entrants to demonstrate that a need is not being served by those currently in the market. In addition, the process of preparing and defending a CON application is often extremely costly and time consuming (particularly if the application is opposed by firms already in the market). 23/ It has also been argued that CON regulation can create opportunities for existing firms to abuse the regulatory process so as further

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21/ Cf. "Nursing homes have little room for patients who cannot pay," Arlington Journal, Apr. 30, 1985 (shortage of nursing home beds in northern Virginia available to Medicaid patients forces some to use nursing homes in other parts of state).

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

23/ See minutes of Feb. 16, 1987 COPN Commission meeting (presentation of J. Rupp, Office of the Attorney General of Virginia) (CON decisions frequently challenged in court, and judicial review takes from nine months to three years); minutes of April 13, 1987 COPN Commission meeting (presentation of Virginia Health Care Ass'n) (cost to nursing home of contested application from $ 5,000 to $ 25,000); minutes of May 11, 1987 COPN Commission meeting (presentation of C. Nelson, Medical Society of Virginia) (professionally prepared CON applications cost up to $ 20,000); see also Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 490-92.

to prevent or delay new competition. 24/ CON regulation therefore makes entry and expansion less likely, or at least less rapid. Firms in any given market need not be as sensitive to price or to consumer demand for new services if they know that it will be difficult and expensive for new firms to enter the market and offer competitive prices or services.

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. 25/ That is why, in both of the hospital merger decisions issued by the Federal Trade Commission in litigated cases, the Commission cited the entry barrier created by CON regulation as a factor significantly contributing to the potential for anticompetitive effects from the mergers. 26/ CON regulation was also cited as an entry barrier in the complaint accompanying a 1985 Commission consent order concerning the acquisition of two psychiatric hospitals in the Norfolk, Virginia metropolitan area. 27/ CON regulation can thus render anticompetitive otherwise lawful

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24/ T. Calvani & N. Averitt, The Federal Trade Commission and Competition in the Delivery of Health Care, at 9-12 (prepared text of February 20, 1986 presentation to Joint Program [of the American Bar Ass'n and the National Health Lawyers Ass'n] on Antitrust Issues in the Health Care Industry) (discussing potential for health providers to use CON process for "non-price predation"); St. Joseph's Hospital v. Hospital Corp. of America, 795 F.2d 948, 959 (11th Cir. 1986) (defendants' misrepresentations to state health planning body concerning plaintiff's CON application not protected from antitrust scrutiny); Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 492.

25/ 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.

26/ American Medical Int'l, Inc., 104 F.T.C. at 200-01 (1984); Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 489-496.

27/ Hospital Corp. of America [Forum acquisitions], 106 F.T.C. at 301-02.

conduct, and aggravate the anticompetitive effects of antitrust violations. 28/

III. Concerns about the Impact of Eliminating CON Regulation on the Nursing Home Industry, and on Medically Underserved Areas, Do Not Justify Its Retention

Some have argued to the COPN Commission that CON regulation is necessary to deal with certain specific problems, even if its effect on health care costs in general does not warrant its retention. For example, the COPN Commission has been told that the elimination of CON regulation would adversely affect the nursing home industry and its principal customer, the Virginia Medicaid program. 29/ Concern has also been expressed that without CON regulation, rural and inner city areas of Virginia will have more difficulty attracting new health facilities and retaining existing facilities. 30/ We address those concerns below.

A. Impact of CON Repeal on Nursing Home Industry

Elimination of CON regulation in the nursing home industry allegedly creates the potential for a surge of new entry, which would substantially increase Medicaid expenditures or threaten the financial viability or quality of care of existing nursing homes. These effects would occur, it has been asserted, because (1) the unit costs of existing homes would increase as their occupancy rates decrease, and/or (2) utilization of nursing homes by Medi-

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28/ 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 anticompetitive effects.

29/ See minutes of April 13, 1987 COPN Commission meeting (oral and written presentations of Virginia Health Care Ass'n).

30/ Id.; minutes of May 11, 1987 COPN Commission meeting (presentation of Statewide Health Coordinating Council); minutes of June 8, 1987 COPN Commission meeting (presentation of Virginia Poverty Law Center).

caid patients would increase to fill the newly-created capacity. 31/

We are not in a position to predict how much growth in nursing home capacity would result from eliminating CON regulation. However, there appear to be no significant incentives for the creation of new capacity, other than capacity that would be used to satisfy consumer demands not met by existing nursing homes. 32/ As noted earlier, Virginia Medicaid generally refuses to pay for costs associated with empty nursing home beds 33/; similarly, empty beds do not yield any revenues from private patients. Those considering building new nursing home capacity therefore will probably be very careful not to build more capacity than needed to meet reasonably anticipated demand. Their demand projections would likely also reflect the strong incentives existing nursing homes have to keep their existing customer base. We would expect that new nursing home capacity would be created only to the extent that there are consumer demands not being met by existing firms, and that existing firms would not face significant occupancy rate decreases unless their existing customers were served more effectively by new entrants.

31/ See minutes of April 13, 1987 COPN Commission meeting (presentations of Virginia Health Care Ass'n and American Health Planning Ass'n). An additional major argument is that CON regulation promotes the construction of nursing homes in areas that need nursing homes but could not support them in an unregulated market. This argument is addressed in Section III.B. below.

32/ Arizona and Utah have been cited to the COPN Commission as states where relatively rapid growth of nursing home capacity occurred after entry deregulation. We note that in 1982, prior to deregulation, nursing home capacity per elderly resident in those two states was much lower than the national average. This suggests that the growth of nursing home capacity may have been largely an appropriate response to acute shortages in those states. By contrast, Virginia's present nursing home capacity per elderly resident was slightly above the national average as of 1982. See National Center for Health Statistics, Nursing and Related Care Homes as Reported from the 1982 National Master Facility Inventory Survey, at 11 (1986). The Johns Hopkins Preliminary Report (at ch. VI) reaches similar conclusions about nursing home capacity growth in Arizona and Utah. It also notes that entry deregulation in Kansas, a state with an above-average ratio of nursing home beds to elderly population, does not appear to have triggered any major growth in nursing home capacity.

33/ See p. 5 above.

It is also far from clear that even significant increases in nursing home capacity would, on balance, have any adverse effect on Medicaid and its beneficiaries. Increased competition resulting from deregulated entry may increase the costs per patient day of nursing homes that lose patients to competitors 34/, but Medicaid has no obligation to pay for those costs (and indeed disclaims any such obligation). Furthermore, competitive market forces can be expected to limit the ability of such nursing homes to pass on the increased per unit costs in the form of diminished quality of patient service (or price increases to private patients), because they would risk losing additional patients to competitors. 35/

In any event, Medicaid may benefit on balance from the offsetting cost savings that increased competition among nursing homes may make possible. For example, to the extent the competition stimulated by entry deregulation reduces prices to private patients, they will exhaust their resources at a slower rate, and thus will become eligible for Medicaid less often and less rapidly. Those reduced prices may also spur greater efforts by nursing homes to minimize operating costs, thus decreasing Medicaid reimbursement of such costs. Medicaid operating cost reimbursement would also decrease to the extent that existing nursing homes are displaced by new competitors that are more efficient. And entry deregulation may reduce Medicaid hospital expenditures for patients whose hospital discharges are presently being delayed until space becomes available in a nursing home. 36/

34/ Minutes of April 13, 1987 COPN Commission meeting (presentation of Virginia Health Care Ass'n).

35/ Similar constraints would face a new nursing home that, for whatever reason (such as being unable to outperform existing firms), could not fill its beds. This prospect would deter the construction of nursing homes in areas where consumer demands are already being met reasonably well by nursing homes already in the market.

Because of these constraints on recovery of costs attributable to unused capacity, it is possible that the most unsuccessful nursing homes in a competitive environment would fail, causing inconvenience to their customers. Id. The alternative to letting such nursing homes fail, however, is to keep them in business despite their inadequate performance, and by eliminating an important incentive for them to improve their performance in order to avoid business failure.

36/ See pp. 7-8 above.

It is possible that, notwithstanding Medicaid's efforts to avoid paying for unnecessary nursing home utilization, increases in nursing home capacity may result in increased utilization of nursing homes by Medicaid patients who do not actually require nursing home care. 37/ However, the substantial unused capacity in nursing homes in many states (and, until recently, Virginia) suggests that state Medicaid programs have had at least modest success in resisting any tendency for increased Medicaid utilization to absorb unused capacity. 38/ In any event, given the overall adverse effects of CON regulation discussed above, creating an artificial shortage of nursing home bed supply through CON regulation seems to be a particularly costly utilization control strategy. Among the most conspicuous of its costs are the inconvenience and indignity to Medicaid patients who need nursing home care but now have difficulty finding nursing homes with available space. 39/

B. Impact of CON Repeal on Promotion of Health Facilities in Underserved Areas

Another concern is that elimination of CON regulation might deprive the state of a mechanism for encouraging the establishment of health facilities in rural and inner-city areas that are relatively unattractive from the business standpoint. In our view, CON regulation is neither necessary nor appropriate as a mechanism to address that problem.

It has been asserted that CON regulation, by shielding health facilities from competition, furnishes a "guarantee of success" necessary for developers to proceed with the construction of

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37/ Compare minutes of March 9, 1987 COPN Commission meeting (presentation of R. Sorrell, director of Virginia Medicaid program) (Virginia Medicaid has effective utilization controls for nursing home care) with minutes of April 13, 1987 COPN Commission meeting (presentation of J. O'Donnell, American Health Planning Ass'n) (presence of unused capacity often undermines utilization controls in state Medicaid programs).

38/ National Center for Health Statistics, Nursing and Related Care Homes as Reported from the 1982 National Master Facility Inventory Survey, at 11 (1986); Center for Health Statistics, Virginia Dep't of Health, 1981 Survey of Virginia Hospitals and Nursing Homes at 29.

39/ See "Nursing homes have little room for patients who cannot pay," supra note 20.

health facilities in inner-city and rural areas. 40/ This argument warrants close and skeptical scrutiny. An unregulated market will provide sufficient incentives to invest in a new health facility (including incentives to incur whatever risks are involved in the venture) in an area with sufficient consumer demand to support a new health facility. The new health facility need only meet the demands of consumers as effectively as it can, and better than can any possible competitors, to maximize its prospects for success. Health facilities that effectively meet consumer demands have no need for protection from competitors; CON regulation only offers protection for those that do not effectively meet consumer demands (because of excessive prices or inferior quality, or because they are inefficient), by deterring or blocking entry by firms that could do better. The COPN Commission should consider carefully whether such state protection from competition really promotes the development of health facilities in underserved areas, and whether the costs of that strategy to consumers (particularly those in the underserved areas) are justified.

CON regulation might also be used to compel firms to allocate resources to underserved areas that they would otherwise have used more profitably elsewhere, such as by denying permission to relocate a facility out of an underserved area, or by requiring creation of a facility in an underserved area as a condition of approval for a more lucrative project. Even where the state legitimately seeks to ensure that an underserved area is served by a health facility the market would not otherwise support, we doubt that CON regulation is the best means to achieve that end. We believe that the COPN Commission should consider alternative mechanisms that would not impair the efficient functioning of health care markets as CON regulation does. 41/

40/ See minutes of April 13, 1987 COPN Commission meeting (presentation of Virginia Health Care Ass'n).

41/ Direct subsidies funded by tax dollars may be a more attractive mechanism for that purpose than maintaining CON regulation. CON regulation, in effect, imposes a "hidden tax" on consumers of health services in the form of higher prices and lower quality. 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. See R. Posner, Taxation by Regulation, 2 Bell J. of Econ. 22 (1971); C. Havighurst, Regulation of Health Facilities and Services by "Certificate of Need", 59 Virginia L. Rev. 1143, 1188-94 (1973).

IV. Conclusion

We believe that the continued existence of CON regulation would be contrary to the interests of health care consumers in Virginia. 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. We believe that concerns about the impact of eliminating CON regulation on the nursing home industry, and on efforts to improve access to health care for medically underserved populations, do not show that maintaining CON regulation would serve consumer interests.

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,

Barbara A. Clark, Deputy

for Jeffrey I. Zuckerman
Director
Bureau of Competition

Enclosed FTC staff reports:

Competition Among Hospitals (1987)
Certificate of Need Regulation of
Entry Into Home Health Care (1986)