

**HB**

**4**

# Alaska State Legislature

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## **SPONSOR STATEMENT HB 4**

### **Medical Facilities Certificate of Need**

By Representative Bob Lynn

HB 4 removes the current Certificate of Need requirement for health care facilities in Alaska boroughs having a population of over 25,000 people. These are mature medical markets with a large enough population that can benefit from price lowering competition while protecting the hospitals of smaller communities as well as nursing homes and residential psychiatric treatment centers that may be more vulnerable.

Alaska continues to see some of the most expensive health care in the country and it continues to rise. The stated purpose of the Certificate of Need (CON) program is to foster a health care system that controls costs and meets changing conditions. Alaska's alarming health care costs prove CON has failed in controlling costs, and in a state experiencing growth and demographic change, the CON law prevents providers from adapting to the changing needs of the community effectively.

Although the cost of services remain high in the state, the CON program has created a substantial impediment to healthy competition and, in effect, represents a state government supportive of anti-trade and hospital monopolies that keep health care prices high. These high health care costs support the thesis that the Alaska's CON program contributes to increased patient expenses.

We have all seen the benefits of competition in communications and other services in Alaska. Given the crisis in high medical costs in Alaska, it is time to restore competition and freedom of choice to the benefit of Alaskan medical consumers.

Your support of HB 4 is respectfully requested.

## **Alaska's Certificate of Need Laws: A History and Argument for Repeal**

By: Jeremy Hayes

### **History of CON**

Thirty five years ago hospitals and medical facilities were being funded by the U.S. Government. In an attempt to control healthcare costs by preventing duplication of medical facilities and equipment, they [Federal Government] created the Certificate of Need program. Congress passed a law in 1974 requiring all states to review and approve capital expenditures in excess of \$1,000,000 by healthcare providers, and by 1980 all 50 states had adopted a Certificate of Need program as a result. In 1986, after the federal funding program was discontinued and after it became clear CON laws were not successful at controlling healthcare costs, Congress repealed the CON requirements for all states, leaving it up to each respective state to decide whether or not to proceed with their CON programs. Twenty states have since repealed CON in one way or another; fourteen states trashing their Certificate of Need programs entirely and six additional states having repealed every part of it save for nursing and long-term care facilities. Alaska is in neither of those groups. Instead of minimizing Certificate of Need restrictions following the repeal of the federal mandate, Alaska has gone in the opposite direction by expanding such restrictions even further. The result has led to Alaska becoming the most restrictive CON state in the country.

### **An Argument in Favor of Eliminating Alaska's CON Program**

Opponents of Alaska's CON program point not only to Congress' act of long ago repealing the state CON requirements, but also to a newer study by the FTC to cast doubt on the successfulness of the Certificate of Need. A June 2004 report released jointly by the Federal Trade Commission and the Department of Justice has these less than flattering things to say about state Certificate of Need laws:

1. Certificate of Need programs are not successful in containing healthcare spending or hospital costs.
2. Certificate of Need programs can actually increase prices by fostering anticompetitive barriers to entry.
3. CON's pose serious anticompetitive risks that usually outweigh their purported economic benefit.
4. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbents market.
5. States with Certificate of Need programs should reconsider whether these programs best serve their citizens' healthcare needs.

While the Certificate of Need process was initially implemented with the intent to control healthcare costs and prevent duplicated services, it seems to have failed in that regard while instead driving prices up, restricting consumer's medical choices, and protecting

hospitals from potential competitors who could accomplish the very goal the program stands for...keeping healthcare costs low.

There has been no evidence that CON's reduce the cost of healthcare in Alaska; **a fact which alone should be sufficient reason to repeal a law specifically designed with that aim in mind.** Alaska has not even studied the costs of services in clinics and surgery centers versus hospitals, and why not? Some of the most extensive research shows CON laws do not reduce healthcare costs and may actually cause them to rise. Duke University's Center for Health Policy, Law, and Management found that CON laws result in higher costs per day and per admission for consumers (and no surprise here: higher hospital profits). Further, they state that CON laws have no effect on overall healthcare spending, the very premise on which these laws are based. A 2003 follow-up study prepared for the Michigan Department of Community Health confirmed the findings, adding that repealing CON laws does not lead to a 'surge' in medical expenditures.

The fact is that outpatient procedures cost significantly less in an ASC than the same procedure performed in a hospital setting (30 – 60% less on average). Surgery Centers offer a safe, efficient, and cost effective environment in which to perform outpatient procedures and have proven the ability to provide some healthcare services at a much lower cost to consumer and physician. **Why would we prevent Alaska's healthcare providers from offering the same quality care at a significant discount to consumers?**

Another goal upon which CON laws were founded was to promote healthcare quality. Again, let's compare hospitals with outpatient surgery centers. Surgery centers are designed and managed to provide its physicians with the optimal environment in which to perform procedures. It offers increased accessibility and operative efficiencies often translating into increased patient satisfaction. Due to these operational efficiencies (which result not only from the environment but also from specializing in only a few procedures), a greater number of procedures can be performed than in most hospital settings without compromising safety or patient care. This allows physicians to utilize their time more effectively, creating greater patient capacity and lower costs as a result. So, offering the same procedure to potentially more consumers at a lower price without compromising care- this suggests a clear advantage to the patient. Originally intended to regulate quality and save Alaskan's money, the Certificate of Need program seems to be having the opposite effect as hospitals control competition at the consumer's detriment and medical expenses climb higher and higher every year.

Hospitals also claim that without protection they would not be able to provide needed, but poorly compensated care. **This has been demonstrated to be false in the several states that have already repealed CON laws.** Hospitals get more efficient with their services while being able to access other revenue sources.

### **The CON Program Protects Hospitals from Competition**

For years in this country entrepreneurial competition has resulted in lower prices, higher quality, and increased access to goods and services for the consumer. The healthcare industry is no different in that the purchaser of their services could benefit greatly from increased competition. Unfortunately for them, the Certificate of Need program consistently impedes this truly American value. Equally appalling is the fact that the CON process takes money away from healthcare services as hundreds of thousands of dollars have been diverted from patient care in order to construct a CON application or to oppose an application for CON by a potential competitor. The potential competitor loses, the consumer loses, and the ones with an already strong foothold in the market (i.e. hospitals) win. Take this example from the FTC/DOJ report cited earlier in which CON laws were used to prevent competitors from offering services that would benefit patients:

A doctor applied for a Certificate of Need to introduce improved cancer radiation therapy equipment. His application was opposed and successfully blocked by existing operators of older, less-effective radiation therapy equipment.

In another case of anti-competitive behavior cited in the report, incumbent providers of home health services in one state have successfully used CON laws for 23 years to prevent a nursing service from entering the market. The owner of the nursing service notes she would charge less for the same service, and that the protection of CON laws has shielded the incumbent from having to offer improved or innovative services.

Sadly, a hospital with CON protection has basically a franchise monopoly which in turn provides no incentive for it to exercise cost controls or better services. The ultimate result of this monopolistic behavior is higher prices fostered specifically by anti-competitive barriers to entry. What happened to the fundamental premise of the American free-market system where consumer welfare is maximized by open competition? CON laws require that new or expanded facilities and equipment be approved by a state government agency or commission. I believe the government intervention in Alaska's healthcare system has impeded competition from delivering full potential to consumers.

### **The CON Program Restricts Consumer's Medical Choices**

The Certificate of Need program has a significant impact on Alaskans' choice in not only where they go to have a procedure performed, but who performs that procedure on them. Needless to say, state law is preventing physicians from opening outpatient facilities which may compete with local hospitals. However, did you know that it's also effecting who receives privileges to perform procedures at the hospitals themselves?

Physicians who have hospital privileges are suddenly facing the fact that they are losing those privileges at the first mention of starting their own outpatient centers. Lawsuits have emerged across the country alleging wrongful denial or revocation of medical staff privileges, exclusive contracts, and foreclosure of markets; and Alaska is no exception.

In addition to losing Alaska's existing physicians who make the mistake of wanting to open their own business, what about the talented, young doctor's who would otherwise love to practice here but learn better from these examples? The vast majority of surgery centers or 'specialty-hospitals' have opened in states that do not have CON programs. Promising physicians may ultimately be apprehensive about practicing in a state which discourages such competition. Often, this may be a physician whose specialty is in high demand in Alaska. Paying off student loans for a career which was restricted in some states but not others may be a determining factor for many physicians.

Patients deserve to receive treatments offered in a manner and location they desire by a physician of their choosing. If people can provide a better service at a lower price, they should be free to do so and the beneficiaries would ultimately be the consumers of healthcare services. Instead of protecting the hospitals from some much needed competition, we should be providing protection against retaliation from hospitals who deny practice privileges to doctor's who attempt to open new outpatient services.

#### **Regulating Quality or Quantity?**

The original federal mandate of state CON laws was centered on *quantity* rather than *quality* of services, simply because medical facilities were being funded by the U.S. Government who had a vested interest controlling what was built. However, once Congress repealed state CON requirements, it was up to each state to draft their own regulations as they saw fit. It was then that many state's, including Alaska, inserted the quality component into the equation (at least on paper). Alaska's Certificate of Need program "is a review process used to promote responsive health facility and service development, rational health planning, health care quality, access to health care, and health care cost containment." Although quality is said to be a fundamental component of the review process, there is little in place to ensure this is happening. While Alaska requires applicants to demonstrate equal access to patients regardless of their ability to pay, provide charity care, and have few or no documented deficiencies in their practice, they do not require these physicians to be board certified, produce outcomes analysis, or provide any other distinct measure of the quality of their services. So, like other components said to be included in the CON review process, I argue that Alaska's Certificate of Need program continues to be quantity-driven rather than quality-driven.

#### **\$1,100,000 Threshold**

A Certificate of Need is required in Alaska for all medical expenditures over \$1,100,000. One must realize the original \$1,000,000 threshold was originally written in approximately 1980. The inflation cost of the \$1,000,000 is equivalent to \$2,536,158 today, yet the increase in the threshold has increased a mere \$100,000.

Perhaps more important than the dollar threshold set forth by the State of Alaska are the requirements for what must be included in that \$1,100,000 amount. Inclusion of such items as the value of the space owned by the applicant based on square footage if the space were leased and net present value of the lease itself will automatically exceed the threshold amount before any other costs are included. Some of these other costs include:

- 1) site acquisition
- 2) site excavation
- 3) construction, demolition, or remodeling of a building
- 4) purchase of equipment, building, or property
- 5) purchase of land
- 6) value of the land

These requirements make it virtually impossible to meet the criteria set forth by the state without necessitating a Certificate of Need.

**Excerpt from Governor Palin's  
Department of Health and Social Services  
Transition Advisory Team**

**December 19, 2006**

Certificate of Need.

- CON has either been eliminated (14 states) or reduced (significant majority of states) since its inception as a federal program. The federal program ended more than 20 years ago when it was found to not be effective. The Federal Trade Commission even concluded that evidence showed that the program actually increased costs substantially through monopolization of health care instead of competition. An often-cited study from the mid 1970's said that more entities providing care always increased utilization, driving up costs; the conclusion was that health care was not a commodity and that competition did not decrease costs. There have been several studies since the 90's, and more recently, showed this analysis is no longer valid, if it ever was. The development of HMO's, PPO's, and policing by the insurance providers has led to reduced costs with competition. This is particularly true when transparency is in force. States that have either rescinded or significantly changed CON (with the majority leaving some CON issues in place with nursing homes but not with ASC's and other medical developments) have seen a drop in their health care costs from 16-24% with the majority coming from reduced hospital charges/surgical charges in competition. Interestingly, almost no hospitals that were not already in financial straits before rescinding of CON have gone out of business; they adjust and go on with business as usual. Last year was a record year for hospital profits in the US. Hospitals are already reimbursed for indigent care through multiple ways including increased reimbursement for all services by Medicare, Medicaid, and private insurers, as well as grants, tax benefits, etc. Alaska has the 2nd most restrictive CON laws in the country and has the most expensive health care.
- Objective, cautious review of the CON would be appropriate. There are settings in which its application may be very appropriate, such as rural communities or in the construction of mental health facilities. A careful review with strategic changes

would be warranted.

- Recruitment would be enhanced with abolition of CON. Physicians, especially surgeons, do not want to move to Fairbanks, where there is a critical need, when they can open their own surgery center/office center in numerous other states without any restrictions. Physicians look for opportunity and some self-determination before investing their training, time, and resources to develop a practice and a life somewhere. Alaska's CON issues, now involving imaging centers as well, make practice here a lot less attractive and add to the healthcare recruitment problem.



**Daily News - Miner**

## Pressure for hospital competition creates health-care battles

By Dermo! Cole  
Published February 9, 2007

**HEALTH CARE:** The medical community is divided over whether competition is just what the doctor ordered or a prescription that will damage Fairbanks Memorial Hospital.

The difference of opinion, which has been developing for years, has grown more intense in recent months with the hospital fighting on multiple fronts to keep new medical enterprises out of the community.

In an affidavit challenging state approval of the Alaska Open Imaging Center office in Fairbanks, Mike Powers, the chief administrator of the hospital, explained one of the hospital's long-standing arguments on local health care.

The nonprofit hospital provides a wide range of medical services to patients regardless of their ability to pay, he said.

"Many of those services are highly unprofitable, including 24/7 emergency, mental health, skilled long-term care, home care, Medicare and Medicaid; additionally FMH expends considerable financial and human resources leading the community master disaster planning, coordinating the chronic inebriate problem and establishing the community diabetes education program," Powers said.

"A few services are relatively remunerative. Those include imaging, pharmacy, surgery and laboratory services. In order for FMH to provide charitable and other subsidized care it is essential that we be able to compete on a level playing field for the more profitable services, such as diagnostic imaging," he said.

He said the imaging center could have a "long-term catastrophic impact" on the hospital.

The counter argument is that the hospital, which is leased to Banner Health, one of the nation's largest hospital operators with 21 facilities in seven Western states, is seeking to defend an unwarranted and lucrative monopoly.

Banner Health, an Arizona nonprofit corporation, and the hospital foundation have not demonstrated how new medical providers would endanger the ability of FMH to serve the public, potential competitors say. On the contrary, new imaging and outpatient surgical offices would improve health-care services for consumers in Interior Alaska and help lower prices, the proponents say. Some advocates also say they would provide a higher percentage of charity care than the hospital.

These contradictory themes have been repeatedly aired in recent weeks through the hospital's appeal of a state decision to allow two new outpatient surgical facilities to open and the hospital's fight against Alaska Open Imaging, a company that was forced by court order to stop performing MRI scans this week.

The hospital contends that Alaska Open Imaging and the two proposed outpatient surgery centers want

to "cherry pick" the most profitable medical procedures.

"As there are already four MRI units in a community of 83,000, another MRI is not needed in Fairbanks," Powers wrote the state on Oct. 28, 2005 about the imaging center.

The Fairbanks hospital defends the state process that determines whether competition in certain segments of the health care industry is to be allowed. The court case that forced Alaska Open Imaging to stop making MRI scans was brought by Banner Health, which argued that the business owners should have applied for a state Certificate of Need.

The owners of Alaska Open Imaging said they did not need a certificate. The Murkowski administration agreed and the center opened, but a Fairbanks Superior Court judge ruled that the certificate was needed. The owners of Alaska Open Imaging said they plan to continue a legal and political fight to offer imaging services in Fairbanks.

Meanwhile, the state recently held a week long hearing on the hospital's appeal of a decision to allow two new outpatient surgery centers in Fairbanks. The state decided choice would be a good thing, but Banner Health said the state failed to consider the "profound financial impact" the competition will have on FMH and its "ability to deliver in the future high-quality emergent and comprehensive health care to the Fairbanks community."

The state decision said there was public support in Fairbanks for competition and that the two groups of doctors backing the clinics had "solid proposals" for surgery services.

In written testimony and at a hearing in Fairbanks last summer, a "substantial majority" of people supported new outpatient clinics, said Karleen Jackson, commissioner of the Department of Health and Social Services.

"Many expressed the view that competition among providers of surgery services would lower the cost of surgery and allow for more convenient scheduling of elective surgery," she said.

The department said that consumers complained of delays, the expense of having to go out of town for surgery and other inconveniences under the present system.

In regard to serving those without insurance, the state said a majority of the doctors at the new clinics would have to enroll as Medicare and Medicaid providers and offer charity care as stated in their applications. The clinic proponents said they would provide charity care to about 2 percent of their patients.

The dispute over the benefits or evils of health care competition is likely to continue in the courts. It will also be a political issue in Juneau this year.

During her campaign, Gov. Sarah Palin said she supported flexibility in regulations to allow competition in health care, contending that it would help consumers and reduce costs. Bills to remove towns the size of Fairbanks from some CON regulations have again been introduced to the Legislature.

The transition report to Palin for the Department of Health and Social Services called for a "cautious review" of the Certificate of Need system. Fourteen states have done away with the CON process and a majority have loosened the rules since it began as a federal program.

There have been some national studies claiming that the CON requirements actually lead to higher health-care costs, but the hospital industry disputes those findings.

The transition team report said that changing the rules to foster competition could help solve the crisis with physician recruitment in Alaska.

“Physicians, especially surgeons, do not want to move to Fairbanks, where there is a critical need, when they can open their own surgery center/office center in numerous other states without any restrictions,” the transition team said.

To advance public understanding of the competing theories that have divided the Fairbanks medical community, a detailed explanation of Banner Health’s Alaska finances seems a necessary step.

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PHOTO: Stu Rothman, 76, registered Master Photographer and a memorable Fairbanks character, died Thursday at Fairbanks Memorial Hospital. There will be a memorial service Saturday at Fort Wainwright at 2 p.m. at the chapel.

*Dermot Cole can be reached at [cole@newsminer.com](mailto:cole@newsminer.com) or 459-7530.*

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**Imaging office permit has far-reaching implications****PROVIDENCE: Certificate of need at issue as centers compete with hospitals.**By BECKY STOPPA  
Anchorage Daily News*(Published: January 24, 2007)*

PALMER -- A medical imaging center that sprouted in June within a stone's throw of Mat-Su Regional Medical Center sparked a debate that, once settled, could have ramifications for hospitals and health care facilities statewide.

Providence Health Systems and a group of radiologists own the center, Imaging Associates of Providence, jointly. It provides radiological evaluations and screenings, including magnetic resonance imaging, or MRI; computerized tomography scans, also called CT scans; X-rays; ultrasounds; and bone density studies, services that Mat-Su Regional just behind it on Woodworth Loop also provides.

At issue is whether the Providence center requires a certificate of need and what impact the competition for imaging services will have on patient costs and the community.

Alaska law mandates that sufficient need exist in a community to warrant new health care projects, said David Pierce, the certificate-of-need coordinator. The Legislature in 2004 amended the law, making independent diagnostic testing facilities subject to certificate-of-need requirements.

Imaging Associates of Providence maintains that it is a physicians' office offering diagnostic services, not an independent diagnostic testing facility. As such, the group claims, it is exempt from the law.

The state health commissioner, Karleen Jackson, initially agreed and allowed the facility to open without a certificate, despite written protests from Mat-Su Regional, which claimed the Providence group threatened the hospital's financial viability.

The commissioner changed her mind in August, though, after a Superior Court judge in Fairbanks ruled in favor of Fairbanks Memorial Hospital.

The hospital filed suit against Alaska Open Imaging, which opened an imaging center there without a certificate of need.

The commissioner had deemed Alaska Open Imaging a physician's office and not an independent diagnostic testing facility. Like Mat-Su Regional, the Fairbanks hospital claimed the imaging center threatened its financial viability.

In the Fairbanks case, Superior Court Judge Niesje J. Steinkruger found the commissioner had ignored the legislative intent behind the 2004 certificate-of-need amendments.



The Imaging Associates of Providence building, a Providence partner, is a few blocks south of Mat-Su Regional Medical Center, which is the light-colored brick building in the background off South Woodworth Loop. *(Photo by JOSHUA BOROUGH / Anchorage Daily News)*

That intent was to level the playing field between hospitals and independent facilities, making both groups subject to the same process, according to the original legal complaint by Banner Health Systems, which operates the Fairbanks hospital.

The commissioner, citing Steinkruger's ruling, ordered Imaging Associates of Providence to apply for a certificate of need for both its Mat-Su and its Anchorage Abbot Road facilities. The Providence group appealed and requested a hearing.

The merits of Alaska's certificate-of-need law have been debated for years.

About 75 percent of the states have similar laws, Pierce said.

Proponents say the process helps keep consumer costs down by weeding out niche providers that might cherry-pick the most profitable services, such as imaging or surgery, leaving community hospitals to bear the burden for more costly and generally unprofitable services like emergent or neonatal care.

That competition, they argue, would force hospitals to raise prices to cover the costs of underused beds and equipment.

Opponents say the law limits patient choice and actually leads to medical monopolies. Gov. Sarah Palin during her 2006 campaign advocated doing away with the certificate-of-need program as a way of promoting competition.

Mark Ackley, Imaging Associates of Providence's chief executive officer, said his group's primary focus is to provide choice for patients in communities that might be underserved. In general, he said, "the quantity of services does not drive prices up."

But the Mat-Su core area is not underserved, says Elizabeth Ripley, Mat-Su Regional director of marketing. Alaska Open Imaging runs an office in Wasilla, and Mat-Su Regional operates two facilities: one at its outpatient center on Bogard Road and one at the hospital.

Neither of the hospital facilities is fully utilized, Ripley said.

She said Mat-Su Regional, along with hospitals around the state, is anxiously awaiting a decision in the Providence hearing -- a decision that Stacie Kraly, the chief assistant attorney general, said should come sometime in March.

"We're hoping to find some clarification as to how these facilities will be identified in the future," Kraly said.

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Anchorage Daily News

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## Palin pushes health care competition

**NEED: Knowles disagrees, saying state certificate reduces costs.**

By TOM KIZZIA

Anchorage Daily News

*(Published: November 1, 2006)*

When it comes to health care reform, Sarah Palin's prescriptions have been pretty broad. But there is one very specific exception. In recent debates, Palin has been saying she wants to do away with the state's certificate of need program -- the gatekeeper agency that must approve any new health care facilities -- as a way of promoting competition.

She's taking sides in a fight that has been going on in Alaska health care for years.

Some medical care providers, including companies that offer MRI scans and other diagnostic imaging services, complain they are prevented now from entering the health care market. They say they could provide better service and drive down costs, and have been trying to get the state program changed or repealed.

"I'm a proponent of some flexibility in the state process in larger markets," Palin said at a Kenai debate last week. Any changes should be made "with the consumer's needs in mind."

Independent candidate Andrew Halcro has taken a position similar to Palin's. Democratic candidate Tony Knowles is on the other side.

"The certificate of need actually reduces costs," Knowles said in a televised debate. He argues that, without some state oversight, entrepreneurs might cherry-pick the most profitable services and leave the costly stuff -- like 24-hour emergency-room care for the uninsured -- to public hospitals.

Defenders of the program say that, without controls, consumers would end up paying more because hospitals would be forced to raise prices to cover the costs of underused beds and equipment.

Palin's stance is in line with changes pushed for several years in Juneau by lobbyist Paul Fuhs, an active volunteer in her campaign.

Fuhs represents Alaska Open Imaging Center, a company battling in court to defend a new imaging center in Fairbanks. Fuhs has organized a nonprofit, Alaskans for Medical Choices and Competition, which is gathering signatures for an initiative to kill the state program in the name of competition.

Fuhs is away deer hunting this week and could not be reached for comment.

Palin's spokesman said her starting point is a bill from last year, HB 287, which would have done away with the state certificate of need for health care facilities in Anchorage,

Fairbanks, Juneau, Mat-Su and the Kenai Peninsula. Spokesman Curtis Smith said she's not yet sure where the exact cutoff line should be.

The state is now subject to medical monopolies, said the bill's sponsor, Rep. Bob Lynn, R-Anchorage.

"If someone wants to open a hot dog stand, shoe store or a health care facility, it's none of the government's business," he said.

Opponents of the bill, which died in committee, say the health care business is more like airlines or commercial salmon fishing, where entry of new competitors is regulated for economic health.

Their concern is that private companies -- imaging centers, day-surgery centers or specialty hospitals -- may enter Alaska's small health care markets and cream off the profits. This raises costs for other hospital services, which must be paid either by consumers or public subsidies.

"Imaging is one of the areas where hospitals actually make some money so they can offset their losses elsewhere, like the 24/7 ER," said Rod Betit, president of the Alaska State Hospital and Nursing Home Association. The group has endorsed Knowles, saying he responded to their detailed questionnaire and Palin did not.

Knowles has also issued a six-page platform of health care reform ideas, including expanded health insurance for children of low-income working families and a state insurance pool accessible to small businesses. He proposes to reduce costs by emphasizing up-front prevention programs and bulk purchase of prescription drugs.

Palin has promised to work with affected parties to find solutions to health care problems. She says she supports flexibility and competition in the field.

The state's certificate of need program does not bar competition, Betit said. It subjects new proposals to scrutiny, subject to criteria spelled out in a 2004 reform law. As an example, he said, six new non-hospital beds were just approved for outpatient surgery in Fairbanks.

But Fairbanks Memorial Hospital recently won a lawsuit blocking a new facility there for Alaska Open Imaging Center, which also has offices in Anchorage, Wasilla and Soldotna.

"The hospitals just don't want the competition," said company CEO Jeff Kinion. "If we can provide a less expensive service, they should improve their service and run them more efficiently."

He said his company likes what it's hearing at the governor debates. "Sarah Palin certainly echoes our thoughts," he said.

Contact reporter Tom Kizzia at [tkizzia@adn.com](mailto:tkizzia@adn.com).

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## Medicaid expenses skyrocket

**OUTLOOK: Program's cost will rise, but a report to lawmakers offers ideas on potential savings.**

By SABRA AYRES  
Anchorage Daily News

*(Published: February 7, 2007)*

JUNEAU -- The cost of Alaska's Medicaid program is expected to triple over the next 10 years, thanks to an aging population that will require expensive, long-term care.

The pattern began more than a decade ago: Medicaid costs gobbling a growing share of the state budget, with the cost of Alaska's Medicaid program leaping from \$362 million to an estimated \$1.2 billion. Although the federal government funds most of the cost, the state's part jumped from \$126 million to an estimated \$388 million, according to state health officials.

The state is experiencing faster than average growth in the number of lower-income and needy populations who need Medicaid coverage. Today nearly one in five Alaskans taps into the Medicaid system. It is the second-largest health insurance payer in the state, while nationally it ranks third, according to a new report commissioned by the Legislature.

Part of the reason for the high price of Medicaid in Alaska is the high costs of medical care in the state. Alaska spent \$1,200 more per Medicaid recipient than the national average in 2003, according to the new report by the Pacific Health Policy Group.

In Tuesday's legislative hearings, Pacific Health proposed several measures to "better control spending or increase federal financial participation" that the state could take to prepare the Medicaid system for future cost increases.

Pacific Health said its recommendations could save the state \$80 million to \$100 million a year.

A key focus of the report is a recommendation for the state to apply for additional federal waiver programs. By doing so, the state would be able to bypass federal regulations on Medicaid spending and create state-specific program guidelines, said Andy Cohen, an author of the report.

The waivers would not bring in more federal funds, but rather would allow the state to tailor Medicaid to Alaska's unique needs, including rural health and an increase in long-term care needs.

Long-term care in the state currently makes up 27 percent of Medicaid spending.

Waiver programs gear the state toward expanding services instead of cutting care, Cohen said.

"Any program that just tries to fill in the gaps by cutting beneficiaries and eligibility ends up creating more holes," Cohen said. "Eventually you run out of quick fixes."

Alaska already has several waiver programs in place, including provisions for the Denali Kid Care program and long-term care systems for some elderly patients and the developmentally and physically disabled.

While using federal funds more cost-effectively is a reasonable goal for the state, the process of securing money from Washington could become more difficult.

In his proposed budget, President Bush is looking to reduce the federal deficit in part with a major five-year reduction in Medicare expenditures to slow the program's annual growth rate from 6.5 percent to 5.6 percent. Reductions would start after 2008.

"All of the things suggested by the report will require approval by the federal government and fit into its cost containment strategy, so it won't be easy," said Jerry Fuller, the Medicaid director at the Department of Health and Social Services.

Fuller said the report covered many of the state's critical short- and long-term Medicaid needs.

The state Senate commissioned Pacific Health last year to examine its Medicaid system. The consulting group has also advised Vermont, Oklahoma, Massachusetts and Mississippi on their Medicaid programs.

One of the report's key focus areas was on reforming the tribal health care system to allow the delivery of all Medicaid-eligible services.

About 125,000 Alaska Natives are all eligible for tribal health benefits, which are paid for by a federally funded Indian Health Service. The tribal system's budget grows about 1 percent to 2 percent a year, which is "not enough to keep up with the pace of medical costs or the pace with the population growth of Alaska Natives in the state, so it's flat funding," Fuller said.

Some 45,000 Alaska Natives carry Medicaid in addition to their IHS entitlements. Medicaid acts as a primary payer if the recipient receives services in a tribal health facility, at no cost to the state. But if a recipient uses a non-IHS facility, the state's contribution to the Medicaid payment is 42 percent.

The report recommended moving the tribal health care system into a managed care system; the state then would pay a set amount with federal funds obtained under a waiver.

The state would save on Medicaid payments made outside of the IHS system, which could then be reinvested into the creation of long-term care facilities for elderly Alaska Natives.

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## **The Other Sides Argument:** Why CON laws should be upheld

### **Eliminating the Certificate of Need requirements would increase health care costs.**

Rebuttal: Since the 1980's when states were set free from the federal requirements to have CON laws, numerous studies have examined the change in health care costs as states eliminated their laws. \*If CON laws were "working" as advertised, then one would expect to see a rise in health care costs in states where laws were eliminated. But in fact this is not the case. One of the most widely referenced studies was written by Duke University Professors Christopher Conover and Frank Sloan and published in the *Journal of Health Politics, Policy, and Law*. They found that output restrictions which resulted from CON laws led to higher not lower costs, and higher profits for existing providers (hospitals). The authors point out that CON laws resulted in higher costs per day and per admission in states with CON regulations, along with higher hospital profits. So, in states where CON laws remained, patients were charged more money, more often than in states that repealed the law. Simply put, the result of repealing CON regulations is lower health care costs for the people of that state. It's just as wrong-headed to think that limiting the supply of health care facilities can reduce health care costs, as it would be to think that oil prices could be brought down with further reductions in oil production.

### **If Alaska's CON regulations are repealed, the hospitals will no longer be able to provide care to the indigent or poor.**

Rebuttal: The argument here is that entry restrictions, and the higher prices and profits that go along with them, are necessary to induce providers to provide free indigent care. So let me get this straight...the cost of health care and the profits to hospitals are purposely kept high by granting monopoly privileges. It is then expected that these excess profits will be used to provide free health care to the indigent. So health care customers are forced to pay a premium created by CON laws and the proceeds from this premium are used to pay for indigent care. This directly contradicts any "cost-savings" argument made by supporters of CON. If patients are paying a higher price in order encourage indigent care, then CON regulations are driving prices up, not down. Additionally, the State's use of non-medical criteria in deciding whether to approve a Certificate of Need (like an applicant's record of providing charity care) is evidence that the process has become arcane and politicized. Finally, the "free" indigent care the hospitals are providing is actually being paid for by the government in the form of huge subsidies granted to them for such care. If the care is paid for by the state, why are we really charging patients a premium?

### **Repealing the Certificate of Need laws in Alaska would lead to the development of ASC's which are cited as a major cause of Hospital closures across the country.**

Rebuttal: From 1987 – 1994, a period that saw more than a doubling of the number of ASC's in this country, the number of Hospital closures declined. Numerous other factors however, have been cited for hospital closures including:

- a) Hospital mergers and acquisitions leading to large scale market consolidation during the 1990's
- b) Failure to adjust to managed care and large reductions in average length of stay
- c) The excess bed capacity of hospitals during the shift from inpatient to outpatient care.

*State Commission on the Efficacy of the Certificate of Need Program and its Effect on Cost, Quality, and Access in Georgia; 08/08/2005*

**Free Market competition can't work as a means of cost-control in the health care industry.**

Rebuttal: The idea that in the area of health care services free market competition can't work as a means of cost control is not grounded in either economic theory or empirical evidence. Competition is widely considered by economists as *the* most effective tool for driving down costs, something Alaska desperately needs. In areas where competition is allowed to flourish, the customer is well served with plenty of options and competitive pricing. Further, it is competition that provides the incentives to discover new technologies and new efficiencies for delivering those technologies to patients. Lastly, believing that CON laws and the bureaucrats that administer them can do a better job at containing costs than the competitive market process is not only wishful thinking, it's the economic equivalent to believing the earth is flat. Everyday experience shows that when the market is free to operate under minimal government oversight, the result is abundant, quality service and low price.

**Repealing CON regulations would lead to duplication of facilities and services.**

Rebuttal: Facility duplication is at the heart of competition. Indeed, the definition of a monopoly market is one where there is no duplication. And this is why customers in monopoly markets lose; they are denied the option of turning to others who are providing "duplicated" services when monopoly providers act like monopolists.

# **Relevant Alaska Statutes For House Bill 4**

Medical Facility Certificate of Need

Sec. 18.07.031. Certificate of need required; relocations.

(a) Except as provided in (c) and (d) of this section, a person may not make an expenditure of \$1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the department:

(1) construction of a health care facility;

(2) alteration of the bed capacity of a health care facility; or

(3) addition of a category of health services provided by a health care facility.

(b) Notwithstanding the expenditure threshold in (a) of this section, a person may not convert a building or part of a building to a nursing home that requires licensure as a nursing facility under AS 47.32 unless authorized under the terms of a certificate of need issued by the department.

(c) Notwithstanding (a) of this section, a person who is lawfully operating a health care facility that is an ambulatory surgical facility at a site may make an expenditure of any amount in order to relocate the services of that facility to a new site in the same community without obtaining a certificate of need as long as neither the bed capacity nor the number of categories of health services provided at the new site is greater.

(d) Beginning July 1, 2005, the \$1,000,000 expenditure threshold in (a) of this section is increased by \$50,000 annually on July 1 of each year up to and including July 1, 2014.

(e) In (a) of this section, "expenditure" includes the purchase of property occupied by or the equipment required for the health care facility and the net present value of a lease for space occupied by or the equipment required for the health care facility; "expenditure" does not include costs associated with routine maintenance and replacement of equipment at an existing health care facility.

Sec. 18.07.111. Definitions (Definitions Page 1 of 2)

In this chapter,

(1) "category of health services" means a major type, program, unit, division, or department of care provided through a health care facility, whether inpatient or outpatient, including an outpatient department, psychiatric wing, kidney dialysis program, radiotherapy, burn unit, or newborn intensive care unit, except that "service" does not include the lawful practice of a profession or vocation conducted independently of a health care facility and in accordance with applicable licensing laws of the state;

(2) "certificate" means a certificate of need issued by the department under AS 18.07.041, 18.07.043, or 18.07.071;

(3) "commencement of activities" means the visible commencement of actual operations on the ground for the construction of a building, the alteration of the bed capacity of a health care facility, or the provision for a category of health services to consumers, which operations are readily recognizable as such, and which operations are done with intent to continue the work until such activities are completed;

(4) "commissioner" means the commissioner of health and social services;

(5) "complete activities" means the substantial performance of the work required to comply with the terms of issuance of the certificate of need to which all parties participating in those activities have obligated themselves to perform;

(6) "construction" means the erection, building, alteration, reconstruction, improvement, extension, or modification of a health care facility under this chapter, including lease or purchase of equipment, excavation, or other necessary actions;

(7) "department" means the Department of Health and Social Services;

Sec. 18.07.111. Definitions (Definitions Page 2 of 2)

(8) "health care facility" means a private, municipal, state, or federal hospital, psychiatric hospital, independent diagnostic testing facility, residential psychiatric treatment center, tuberculosis hospital, skilled nursing facility, kidney disease treatment center (including freestanding hemodialysis units), intermediate care facility, and ambulatory surgical facility; the term excludes

(A) the Alaska Pioneers' Home and the Alaska Veterans' Home administered by the Department of Health and Social Services under AS 47.55; and

(B) the offices of private physicians or dentists whether in individual or group practice;

(9) "nursing home bed" means a bed not used for acute care in which nursing care and related medical services are provided over a period of 24 hours a day to individuals admitted to the health care facility because of illness, disease, or physical infirmity;

(10) "residential psychiatric treatment center" means a secure or semi-secure psychiatric facility or inpatient program in a psychiatric facility that is licensed by the Department of Health and Social Services and that provides therapeutically appropriate and medically necessary diagnostic, evaluation, and treatment services

(A) 24 hours a day for children with severe emotional or behavioral disorders;

(B) under the direction of a physician; and

(C) under a professionally developed and supervised individual plan of care designed to achieve the recipient's discharge from inpatient status at the earliest possible time that is intensively and collaboratively delivered by an interdisciplinary team involving medical, mental health, educational, and social service components.

## Policy Brief

### Failure of Government Central Planning Washington's Medical Certificate of Need Program

by John Barnes, Policy Analyst  
January 2006

#### I. Introduction

Imagine your community is home to a nursing care facility that has operated for years with optimal customer satisfaction. It provides quality care and assistance, its facilities are modern and clean, and the staff is excellent. The nursing home is exceeding capacity and its operators look at the growing demand and decide to expand the facility by adding five beds. They consult their experts, study options and projections, and, after careful consideration secure a building permit and begin construction. Sounds reasonable, right? Well, they just broke the law.

Washington is one of thirty-seven states (including the District of Columbia) that require government permission to open or expand most kinds of health care facilities. In addition to the usual building permits and zoning approval, the state must grant a Certificate of Need (CON) before such facilities can be built, expanded or modified significantly. The 14 states that do not have CON laws include large states like California, Pennsylvania, and Texas, and together comprise about 35% of the U.S. population (a full list appears on page 8). [1]

Washington's Certificate of Need law applies only to providers of health care. It functions as a control valve to limit the supply of health care. Hospital and clinic managers must comply with a complicated set of established procedures and formulas to prove to state bureaucrats that there is or will be a need for whatever service they seek to provide. Without successfully navigating the CON process, it is illegal to offer new health care services to Washington residents.

*Federal lawmakers proposed solving a problem created by government intervention by imposing more government intervention.*

Public policy in Washington should focus on assuring access to affordable, high quality health care for all the people of our state. The Certificate of Need program fails to advance this fundamental goal. This study describes the history of the Certificate of Need concept, summarizes how the Washington law works, compares its stated goals with actual performance, and presents practical policy recommendations for improving access to affordable health care for the people of Washington.

#### II. Background

##### Origins of Certificate of Need

The roots of the Certificate of Need idea date back to 1964 in Rochester, New York. Local businesses and Blue Cross established a community health planning council composed of consumers, insurers and health care providers to study the need for hospital beds. The group decided there was a surplus and recommended that the state restrict supply in order to prevent what was then considered too many health care facilities. This effort culminated in New York's passage of the nation's first Certificate of Need law in 1966. [2]

##### Federal Certificate of Need Law

Also in 1966, Congress enacted the Comprehensive Health Planning Act. States receiving federal funds under public health and social security programs were required to establish local and state health planning agencies. Those states that already had planning agencies were required to expand the reach and authority of these departments.

In 1972 the federal government amended the Social Security Act to compel all states to review health care capital expenditures in excess of \$100,000. Failure to comply meant a state would be denied Medicare and Medicaid reimbursements for capital expenditures. [3] This provision served as the skeletal beginnings of a national Certificate of Need law. [4]

In 1974, during a time when many lawmakers were pushing for a complete government takeover of the health care system, Congress passed the National Health Planning and Resources Development Act (NHPRDA). [5]

The NHPRDA law directed each state to examine proposed health care facilities and "make findings as to the need for such services." [6] If the states did not comply with the Act's directives, the federal government would withhold funding. [7] This created strong incentives for states to implement far-reaching health care planning regulations.

The NHPRDA law recognized that "the massive infusion of Federal funds into the existing health care system" had severely distorted the health care market by "contribut[ing] to inflationary increases in the cost of health care." [8] Ironically, federal lawmakers proposed solving a problem created by government intervention by imposing more government intervention.

#### **Distortions Created by Cost-Based Reimbursement**

At that time, health care was built on a cost-based reimbursement system. Price-based competition had little, if any, role in health care because providers were able to recover full cost from Medicare and Medicaid, no matter how high. The system provided little incentive for cost reduction. "There are presently inadequate incentives for the use of appropriate levels of health care," lawmakers said. [9] They believed that excess facility supply led to increased costs of business, and that those increased costs would be passed on to patients. They intended top-down health planning and strict Certificate of Need laws to constrain supply and therefore control prices.

Along with price inflation, federal lawmakers believed that a market distorted by the infusion of federal tax dollars led to poor distribution of health care facilities. Thus another purpose of early health planning and Certificate of Need laws was to control the geographic distribution of health care. Lawmakers believed that "one efficient and fully-utilized piece of equipment was better than two that were under-utilized." [10]

In the years following the passage of the NHPRDA, states began adopting Certificate of Need laws. The primary goal of these laws was to contain rising health care costs. Eventually every state and the District of Columbia adopted Certificate of Need regulations.

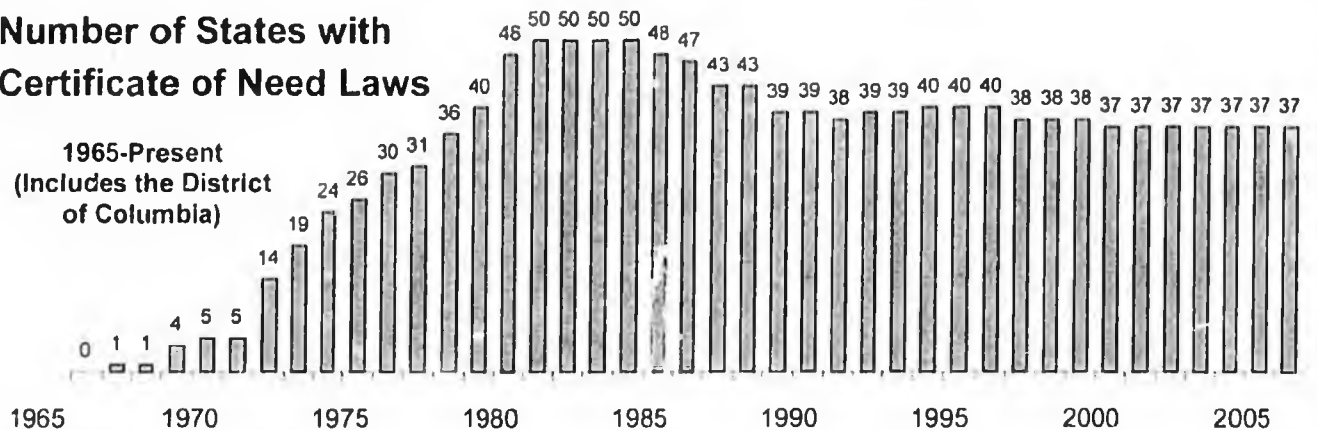
#### **Repeal of Federal Law**

In 1982, the federal government acknowledged the failure of its Certificate of Need law to reduce health care costs and repealed the mandatory health planning law. [11] In the years following federal repeal, 14 states eliminated their medical facility control laws as well. Thirty-six states and the District of Columbia retained their Certificate of Need laws. Washington is one of these. Figure 1 shows the number of states having Certificate of Need laws from 1966 to today. [12]

Figure 1

## Number of States with Certificate of Need Laws

1965-Present  
(Includes the District of Columbia)



### III. Overview of Washington's Certificate of Need Program

Washington imposed its first Certificate of Need requirements in 1971. [13] Later the program was changed to adapt to the requirements of the 1972 Social Security Act amendments and the 1974 NHPDA law. With these early adjustments, the program as created in the 1970s remains in force today.

The Certificate of Need program forms the backbone of centralized health planning in the state. The five stated purposes of health planning are: [14]

- "To promote, maintain, and assure the health of all citizens in the state, to provide accessible health services, health manpower, health facilities, and other resources while controlling excessive increases in costs, and to recognize prevention as a high priority in health programs, as essential to the health, safety, and welfare of the people of the state."
- "That the development of health services and resources, including the construction, modernization, and conversion of health facilities, should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation."
- "That the development and maintenance of adequate health care information, statistics and projections of need for health facilities and services is essential to effective health planning and resources development."
- "That the development of nonregulatory approaches to health care cost containment should be considered, including the strengthening of price competition."
- "That health planning should be concerned with public health and health care financing, access, and quality, recognizing their close interrelationship and emphasizing cost control of health services, including cost-effectiveness and cost-benefit analysis."

The Certificate of Need program is administered by the state Department of Health. Between 1971 and July 2005, the state made decisions on 1,786 applications for Certificate of Need. Of those decisions, 177 applicants were denied permission to provide new medical services. Two Certificates of Need were rescinded after the Department's decision to grant was overturned on appeal. [15]

#### Washington Compared to Other States

Washington has one of the most stringent Certificate of Need laws in the country. Fourteen states have no Certificate of Need restrictions on building new medical facilities, while 36 states and the District of Columbia have such programs in place.

The scope of Certificate of Need laws varies from state to state. Some are highly detailed. In Alabama, for example, hospital managers must obtain a Certificate of Need before purchasing a new ultrasound machine. Connecticut requires state approval before a health care office can buy certain computer equipment. [16] Other states, such as Louisiana and Nebraska, apply their Certificate of Need law to only one or two types of service, leaving health care managers free to make all other decisions without the health department's prior approval.

Comparing state Certificate of Need programs is no easy task. Certain regulated medical services are more common or are more expensive than others. For example, one state might cover more medical services that are rare, like organ transplants, while another covers fewer services, such as CT scans, that are central to the health care infrastructure and affect more patients.

Figure 2 shows a comparison of Certificate of Need requirements in the fifty states and the District of Columbia. The comparison gives each state a weighted ranking, with higher numbers representing larger regulatory burdens. Under this method, Connecticut ranks the highest. Its law covers 24 services and expenditures, earning a rank of 28.8. Alaska is next highest - it covers 26 services and expenditures, but collectively these have less scope, earning a rank of 26. The last fourteen states in Figure 2 are ranked zero because they have no Certificate of Need laws.

Washington is the 13th most regulated in the country, with a weighted ranking of 12.8. Washington's Certificate of Need law covers 16 different health care services and expenditures. Washington's number 18 ranking represents a higher level of regulation than may appear at first, for two reasons. First, almost two-thirds of the states have a lower level of regulation than Washington. Second, the rating method takes into account the scope of a state's regulatory burden, in addition to its place on the list. For example, Washington ranks only six places up the list from Iowa, but its weighted level of regulation is twice as high.

Figure 2 (Available in pdf)

*Washington's Certificate of Need law covers 16 important health care services, making the state one of the most heavily regulated in the nation.*

#### **IV. Description of the Project**

##### **What Washington Law Covers**

As reflected by its high national ranking, Washington's Certificate of Need law is very broad. It covers every major kind of health care facility and most major health services. [17] Without prior state approval, it is illegal in Washington for any person to:

- Construct, establish or develop a health care facility, including;
  - Hospitals
  - Kidney disease treatment centers (dialysis)
  - Psychiatric hospitals
  - Ambulatory surgical facilities
  - Nursing homes
  - Hospices
  - Certain continuing care retirement communities
  - Home health agencies
- Sell, purchase or lease part or all of any existing licensed hospital, regardless of profit or non-profit status;
- Increase the number of kidney dialysis treatment stations;
- Increase the number of hospital beds available to patients, or redistribute the number of existing beds among acute care, nursing home care and boarding home care;
- Make any improvement to a nursing home that exceeds two million dollars;
- Replace an existing nursing home with a new one;

- "Bank" beds at a nursing home, that is, set aside some beds to reduce the home's total number of regulated beds;
- Establish a new tertiary health service offered by a health care facility that was not offered by that health care facility within the 12-month period prior to the time the facility will offer the services. Tertiary health services include:
  - Specialty burn services
  - Intermediate care nursery
  - Neonatal intensive care
  - Transplantation of solid organs
  - Open heart surgery
  - Inpatient physical rehabilitation, Level I for persons with nonreversible multiple function impairments of moderate-to-severe complexity.
  - Specialized inpatient rehabilitation services.

○

Washington's Certificate of Need law leaves few stones unturned. State lawmakers have placed all but a handful of medical services under the Certificate of Need umbrella. The exceptions include narrow services like air ambulance services, business computers and diagnostic imaging.

**Timelines in the Process**

The Certificate of Need law is costly and time consuming. It includes a number of timelines intended to serve as a chronological framework for the process. [18] In practice, however, these deadlines mean little, since they are seldom met. Figures 3 through 6 show the required timelines.

*Washington's Certificate of Need law leaves few stones unturned, with all but a handful of medical services being subject to Certificate of Need requirements.*

Figure 3

Number of Days	Regulatory Action
0	File a letter of intent with the Department of Health
30	File application for Certificate of Need
45	Department of Health screening period (15 working days)
90	Deadline for responding to screening questions (up to 45 days)
95	Notification of beginning of review (5 working days)
130	End of public comment period (35 days)
140	End of rebuttal period (10 days)
185	Department of Health decision date (final review period: 45 days)
<b>Total Time for Regular Review: Approximately 6 Months</b>	

There is also a timeline for an expedited review process. [19] If a business or organization is acquiring an existing health care facility, they fall into this category. Expedited reviews also include

predevelopment expenditures and projects intended to correct deficiencies such as safety hazards or state licensing requirements. Figure 4 shows the expedited review timeline.

Figure 4

Number of Days	Regulatory Action
0	File a letter of intent with the Department of Health
30	File application for Certificate of Need
45	Department of Health screening period (15 working days)
90	Deadline for responding to screening questions (up to 45 days)
95	Notification of beginning of review (5 working days)
115	End of public comment period (20 days)
125	End of rebuttal period (10 days)
145	Department of Health decision date (final review period: 20 days)
<b>Total Time for Expedited Review: Approximately 5 Months</b>	

If the Department of Health denies a Certificate of Need, the applicant can ask for interim reconsideration. [20] If the Department of Health upholds its denial of a Certificate, the appeal process can begin. The first step is the Administrative Appeal, which takes the form of an adjudicative proceeding. [21] Figure 5 shows the timeline for the Administrative Appeal.

Figure 5

Time	Regulatory Action
	1. File application for adjudicative proceeding (deadline: within 30 days after Department of Health decision)
20 days	2. Administrative Law Judge* issues scheduling order and notice of hearing
4 to 5 months	3. Hearing before Administrative Law Judge
1 to 2 months	4. Post-hearing breifs submitted
1 to 2 months	5. Administrative Law Judge issues decision
<b>Total Time for Adjudicative Proceeding: 7 to 10 Months</b>	

Health whose role is made in accordance

\*The Administrative Law Judge is an employee of the Department of Health whose role is to determine whether the Department's denial of a Certificate was made in accordance with the applicable statutes and regulations.

If the Administrative Appeal upholds the Department of Health's decision to deny a Certificate of Need, the applicant may then proceed to Judicial Review. The Judicial Review process is an appeal to Superior Court. Figure 6 shows the timeline.

Figure 6

Time	Regulatory Action
	1. File Petition for Judicial Review in Superior Court (deadline: within 30 days after Administrative Law Judge decision)
6 to 10 Months	2. Trial (oral argument based on administrative record; no new evidence)
1 to 2 Months	3. Superior Court issues decision
<b>Total Time for Judicial Appeal: 7 to 10 Months</b>	

<b>Total Potential Time for Certificate of Need Process: 2+ Years</b>
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The Judicial Review can reverse the Department of Health's decision and issue a Certificate of Need. If that happens, then the project may begin. If the Judicial Review upholds the denial, then no Certificate of Need will be issued and the intended project cannot commence. The total potential time for the Certificate of Need Process is more than two years.

**Other Factors in the CON Decision**

There is much more to the process than a mere timeline. The process for acquiring a Certificate of Need depends largely on the kind of project involved. The flow chart in Figure 7 (available in pdf), at the center of this Policy Brief, shows the process required for opening a new surgery operating room.

Ambulatory surgical centers are outpatient surgery facilities that use a doctor's office environment for minor surgeries that do not require overnight stays in a hospital. These centers began appearing in the early 1970s as a way to reduce the overhead cost of conducting simple, low-risk treatments. Today there are about 4,600 centers nationally, a 53% increase over the number operating just five years ago. [22] The state Department of Health has developed a complicated formula for analyzing the perceived need for such centers in Washington.

The Department of Health uses numerous criteria for making this determination. At their core is a numeric formula that uses current and projected changes in population and medical capacity to calculate "net need." [23]

Other factors influence the decision as well. The Department of Health, not the marketplace, determines whether or not a proposed project is financially feasible and whether or not the project will, "foster containment of the costs of health care." [24] The Administrative Code outlines 31 criteria and sub-criteria that state managers use to decide on the need for a proposed health care facility or service. [25] Those criteria include:

- " The applicant's past performance in meeting obligations under any applicable federal regulations requiring provision of charity care.
- " The existence of any civil rights complaints against the applicant.
- " The effect of the reduction, elimination, or relocation of a health service on the ability of low-income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups and the elderly to obtain needed care.

- " The likelihood that all residents of the area, including low-income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups and the elderly will have access to the proposed health service.
- " That the proposed project will not have an adverse effect on health professional schools and training programs.

The criteria are much the same if an applicant proposes to build a hospital. The key difference is an additional formula to calculate the number of hospital beds. Figure 8 shows this process. [26] This complicated formula, drafted in 1979 and still in use today, is based on a methodology outlined in Section 4 of the State Health Plan. Section 4 alone is over 40 pages in length.

Figure 8 (Available in pdf)

#### **V. Review of the Effectiveness of Certificate of Need**

The Certificate of Need law is intended to restrain costs and increase access to health care. The process actually has the opposite effect. By forcing anyone interested in building or expanding health care facilities to maneuver through an arcane maze of bureaucratic regulations, the state makes it harder to provide modern, flexible, community-responsive health care. This section reviews the Certificate of Need program and assesses its effectiveness based on its stated goals.

##### **The Basic Reasoning behind the CON Law Is Faulty**

The chief argument proponents use to justify the Certificate of Need law is that surplus capacity in health care facilities leads to duplication of services and increased operating costs. These higher costs, they say, are then passed on to insurance companies and patients in the form of higher prices. By regulating the supply, surplus will be avoided. Health care is an "essential of life," planning advocates say, and the market is incapable of producing the necessary supply of hospital beds on its own. The reasoning behind this justification is faulty for two reasons.

First, the realities of the economy make no distinction between things deemed "essentials of life" and any other product or service. The harmful impact of over-regulation on both is the same. Health care is no different than any other product or service in our economy and the same dynamic market forces determine the quality, availability and price of it. In fact, the more essential a product or service is to meeting basic human needs, the more important it is for policymakers not to place artificial restraints on it.

Second, the "essentials of life" argument for regulating health care overlooks the even more fundamental needs of life that are bountifully provided through vigorous competition in the free market. Food, clothing, housing and transportation are vital and immediate human needs. For the vast majority of Washington residents these needs are met through a vibrant system of private buying and selling. In these cases the government's role is properly limited to protecting public safety, enforcing voluntary contracts and assisting the needy. Everyday experience shows that when the market is free to operate under minimal government oversight, the result is abundance, quality service and low price.

The more health care providers, consumers, and insurers are permitted to communicate freely in a normally-functioning marketplace, using advertising, price signals and other means, the more society will be able to provide sufficient affordable health services to meet essential human needs. The rapid growth of Health Savings Accounts and consumer-directed health plans is an indication of this trend. The Certificate of Need law works in the opposite direction, blocking fast and accurate communication between patients and health care providers, and preventing providers from responding to changing needs in the community.

##### **Certificate of Need Laws Do Not Save Money**

The assertion that Certificate of Need laws save money is further refuted by a number of recent studies. In July 2004, the Federal Trade Commission and the Department of Justice found that, "the reason that CON has been ineffective in controlling costs is that the programs do not put a stop to 'supposedly unnecessary expenditures' but merely 'redirect any such expenditures into other areas.'" [27]

In 1999, the Washington State Joint Legislative Audit and Review Committee (JLARC) reviewed the Certificate of Need law. JLARC found that the Certificate of Need law has not had any clear success in meeting its legislative goals. Its report, titled "Effects of Certificate of Need and Its Possible Repeal," reached several conclusions:

"The study found that CON has not controlled overall health care spending or hospital costs. The study found conflicting or limited evidence about the effects of CON on the quality and availability of other health care services or about the effects of repealing CON." [28]

The study went on to assess the effectiveness of the CON law in terms of cost, quality and access.

**Cost:**

- " The weight of the research evidence shows that CON has not restrained overall per capita health care spending. [29]
- " Numerous studies have shown that CON has not controlled overall hospital spending. One study found that CON actually increased hospital expenditures.

**Quality:**

- " Certificate of Need concentrates volume, and the research evidence is strong that higher volumes of certain surgical procedures can lead to better outcomes. [30]
- " CON has a mixed record in concentrating volume. For example, studies show that CON was not effective in Ohio and Delaware in increasing volume, but did concentrate volume for some services in Pennsylvania. [31]

**Access:**

- " Washington's CON law has had no effect on improving access. [32]
- " In some instances, CON rules are used to restrict access by preventing the development of new facilities. [33]

**CON Laws Do Not Increase Access**

In King County there are 120 retirement communities, but only twelve are tied to nursing homes. Almost all operating nursing homes are 30 to 40 years old. [34] Waiting lists are common at even mediocre facilities. Due to Certificate of Need restrictions and other state-imposed regulations, additional nursing homes are not being added as the population ages. Under normal market conditions, the supply of elder care would increase as the need increases. The burden of the CON law disrupts this natural development.

In addition to limited access, those seeking nursing home care face high costs, even though the Certificate of Need framework is intended to reduce costs. Continuing care retirement communities tied to nursing homes require monthly payments along with large up-front fees, which can range from \$270,000 to \$400,000, and are simply beyond the reach of most people. [35] The situation indicates that the Certificate of Need law has not been effective in easing the rising burden of medical expenses for the elderly.

Studies throughout the U.S. have arrived at similar conclusions: the data indicate that a program designed to reduce cost, improve quality and promote access has not achieved any of these goals. [36] In addition, the 14 states with no Certificate of Need laws, which are home to more than one in three Americans, show no significantly higher rate of health care spending due to the lack of such laws.

**Assessing Promise and Performance:**  
**The Certificate of Need law has not met its stated goals**  
(All quotes are from Revised Code of Washington 70.38.015)

The crafters of Washington's health planning and Certificate of Needs law had clear goals in mind. Thirty years later, it is possible to assess the law's success or failure in meeting its goals. A clear pattern emerges. Washington's Certificate of Need process has not achieved what the authorizing law promised.

What the law promised: Health planning "should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation."

**The situation today:** A quick glance at the Certificate of Need procedure for surgery operating rooms (see figure 7) reveals a process that is anything but orderly. Moreover, health care providers seeking permission to build would hardly use the word "planned" to describe the process and its results. For those who must submit to it, the Certificate of Need process is expensive, inconsistent and unpredictable.

What the law promised: "The development of nonregulatory approaches to health care cost containment should be considered."

**The situation today:** There is far more regulation of health care today than when the CON law was enacted. State law now imposes 49 separate mandates on every health insurance policy sold in Washington. Hospitals, clinics and doctors must comply daily with stacks of complicated regulations that inhibit the practice of medicine. Under CON, the state alone decides what health care facilities are allowed and where they will be built.

What the law promised: "Price competition should be strengthened."

**The situation today:** There is far less price competition in health care today than there was when the CON law passed. Patients and providers are generally unaware of health care pricing and usually have no idea how much a particular treatment costs. The CON law directly stifles price competition by discouraging existing providers from offering new services, and by blocking new competitors from entering the marketplace.

What the law promised: "Health planning should be concerned with public health care financing, access, quality, emphasizing cost control of health services."

**The situation today:** The CON law has failed to control health care costs. In recent years the cost of health coverage has increased up to five times faster than inflation. The CON law has also failed to increase access to health care. In western Kittitas County, for example, one ambulance and one paramedic provide service for an area of some 800 square miles. [37]

**Certificate of Need Suppresses Competition and Creates Monopolies**

Certificate of Need appeals are a legal mechanism that health care organizations and facilities use to fend off competition. A review of the Certificate of Need action log dating from 1971 to July 2005 reveals that the issuance of a Certificate of Need is often appealed by one or more medical businesses that perceive an economic threat if a new medical facility opens in their area.

When the Department of Health granted Swedish Health Services permission to build an ambulatory surgery center in Bellevue, Overlake and Evergreen medical centers asked the Department to reconsider on the grounds that Swedish's plans would intrude upon their health planning area. The Department upheld its original decision, so Overlake and Evergreen then filed an appeal. The adjudicative hearing resulted in Swedish losing the Certificate of Need.

The Bellevue situation is not an isolated incident; this happens on a regular basis. Easy appeal is built in to the Certificate of Need process. No reasoning or criteria is required for "affected parties" to request a hearing and appeal a decision. [38] Appeals center on the cryptic minutia of the way state employees interpreted the rules, contesting, for example, the method of regression analysis, the identification of service areas, and the definitions used to determine price competition and patient choice. [39]

*The Certificate of Need process functions as protection for monopolies, protecting businesses already in the market while keeping competitors from entering.*

The Certificate of Need process functions as protection for monopolies, insulating businesses that are already in the market and keeping competitors from entering. Anti-competitive activities that would be severely punished by federal anti-trust laws if attempted by other private companies are sanctioned and promoted by the state when they involve medical providers.

Even when established health care organizations are unable to prevent competitors from entering their area, they usually succeed in using the Certificate of Need appeals system to block market entry to new providers for significant amounts of time, often years.

A 2004 study by the Federal Trade Commission and the Justice Department reported that:

"...where CON programs are intended to control health care costs, there is considerable evidence that they can actually drive up prices by fostering anticompetitive barriers to entry." [40]

The same study found that the Certificate of Need process:

"has the effect of shielding incumbent health care providers from new entrants. As a result, CON programs may actually increase health care costs, as supply is simply depressed below competitive levels." [41]

Increasingly, hospitals are facing competition from ambulatory surgery centers, which offer minor surgical procedures that do not require an overnight stay. Often times these facilities offer the same surgery as a hospital but at lower prices. It is one of the ways the market is adjusting to make health care delivery more efficient and cost effective. Established hospitals, however, use the Certificate of Need law to prevent ambulatory surgery centers from opening in their service areas, thus blocking access to health care choice and lower costs for consumers.

The 1974 national health planning law (NHPDA) itself noted the need for incentives to develop more economical ways of treating minor surgery patients without formal admission into a hospital. Ironically, the very laws designed to foster alternatives to expensive hospital stays are today used against innovative providers who are trying to offer those very alternatives.

#### **Discouraging Public Debate**

Fear of endangering their prospects for success prevents many applicants from publicly questioning or debating the process. When asked about the state refusing to issue his company a Certificate of Need, Bill Wolverson of Renal Care Group said "I'm not going to be able to speak for the record; we're about to start an appeals process." [42]

Representatives of other organizations have expressed similar sentiments about applications and appeals in the pipeline. During testimony before the Senate Health and Long-Term Care Committee on a bill calling for a study of the Certificate of Need program, one expert said, "Certificate of Need applications have become much more of a political struggle than they should be." [43] Applicants are equally reluctant to appear critical of the process or departmental staff.

*"I'm not going to be able to speak for the record; we're about to start an appeals process," remarked Bill Wolverson of Renal Care Group.*

## VI. Problems and Delays in Certificate of Need Review

The foregoing section examined the basic weaknesses in the Certificate of Need law. Research shows the law is not fulfilling its goals because the concept on which it is based, top-down limits on health services through state central planning, is fundamentally unsound. A review of the law as implemented in practice indicates the process suffers from other shortcomings as well, primarily added delays and complications in the process of gaining state approval for a project. Even if the problems discussed below were addressed, however, the foundational defects in the Certificate of Need idea would remain.

### CON Process Exceeds Legal Timelines

In May 2005, the Department of Health denied permission to Swedish Medical Center and Overlake Hospital Medical Center to build new hospitals in Issaquah. This decision was the culmination of a regulatory tug-of-war that had been going on quietly since the two hospitals submitted their plans to the state more than a year before. [44] This does not include the six months Swedish and Overlake spent developing the proposal in the first place.

A review process that was supposed to provide expedited review and include public input did neither. [45] After more than a year of paperwork, lengthy meetings and countless staff hours, officials at Swedish and Overlake ended up right back where they started, and the people of Issaquah were deprived of new medical services that two respected and established hospitals were eager to provide.

Figure 9 shows the timeline for the Issaquah hospital decision process. [46] Compare this with the statutory timeline shown in Figure 3. What should have taken just over six months actually took more than thirteen months.

Figure 9

Timeline for Proposed Issaquah Hospital	
Date	Action
April 6, 2004	Letter of intent submitted
July 21, 2004	Applications submitted
July 22, 2004 - Feb. 6, 2005	Certificate of Need office's pre-review activities (application screening / public comments begin)
Feb. 7, 2005	Certificate of Need office begins review of applications
March 7, 2005	Public hearing conducted / end of public comment
March 25, 2005	Rebuttle documents submitted to Certificate of Need office
May 10, 2005	Certificate of Need office makes decision, does not issue Certificate of Need to Swedish or Overlake
<b>Total Time for Application Process: 13 months</b>	

The Issaquah case is not a lone example. A sampling of recent Certificate of Need application timelines, shown in figure 10, reveals that the process typically takes much longer than the law says it should. In these cases, the office handling Certificate of Need requests delayed giving answers by an average of 60% beyond the time required by law.

Figure 10

Project	CON Process Should	Actually Took:
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	have Taken:	
Sale of Providence Yakima Medical Center to Health Management	5 months	8 months
Semper-Care establishing long-term acute care hospital in Spokane	6 months	9 months
Franciscan Health System establishing an ambulatory surgery center in Gig Harbor	6 months	9 months
Hospital Proposal in Gig Harbor	6 months	11 months
<b>Average Delay months</b>		<b>3.5</b>

### CON Process Takes Longer than Planned Construction

The time for securing a Certificate of Need usually exceeds the time it takes to actually build the proposed medical facility. For example, in May 2003 the state granted Swedish Health Services permission to build an ambulatory surgery center in Bellevue. The process required six months for initial planning and eight months for Certificate of Need approval.

*So far, Swedish has spent three years processing Certificate of Need paperwork, for a facility that would take only 15 months to build.*

Swedish's competitors, Overlake and Evergreen medical centers, immediately appealed the Certificate of Need issuance. Today, more than two years after the state gave Swedish the go-ahead to begin construction, the project remains in limbo. The process dragged on so long that Swedish lost its lease option on the building it planned to convert to into the new surgery center. So far Swedish has spent three years processing Certificate of Need paperwork for a facility that, if approved, would take only fifteen months to complete. In the meantime, thousands of surgery patients who would have benefited from the new facility have been forced to go elsewhere or do without.

### Community Input Is Often Ignored

Defenders of the Certificate of Need programs call it a "flexible tool" that "helps protect the critical health care infrastructure" by means of "community based planning." [47] There is no objective evidence, however, that Certificate of Need decisions include community feedback.

The recent battle over the proposed hospital in Issaquah serves as a case in point. On March 7, 2005, the Department of Health held a public hearing in Issaquah for the community to voice its concern about Swedish and Overlake's desire to build a hospital in their area. More than five hundred people attended, many of them physicians. The real debate among participants was not whether or not there should be a hospital - only eleven people said the community did not need a new hospital - but rather who should build it, Swedish or Overlake.

*The views of the vast majority of people who attended the public meeting had no effect on the final decision.*

[48] As we know, the Department of Health denied both applications. The views of the vast majority of people who attended the public meeting had no effect on the final decision.

In contrast to the Issaquah case, consider what happened in Gig Harbor. Franciscan Health System proposed building a 112-bed hospital there, and in May 2004 the Department of Health announced its approval of an eighty-bed hospital. In announcing its decision, the Department of Health said, "public input overwhelmingly supported a hospital in Gig Harbor, and that public sentiment was substantiated in the fact-based analysis." [49]

Comparing what happened in Issaquah with Gig Harbor demonstrates that the public's view only matters when it agrees with the state's "fact-based analysis." Public input only seems to be relevant when it supports the pre-set designs of the planning process, and is ignored when it contradicts the regulatory formulas.

## VII. Examining Arguments Made in Support of Certificate of Need

Advocates of Certificate of Need make a number of arguments to defend their views, and cite a number of states where they say it is working as intended. On closer examination, however, the evidence cited typically relies on a narrow set of data to back up these claims.

Planning proponents frequently point to studies by Ford, DaimlerChrysler and General Motors that compare health care costs in states where they have employees. For example, DaimlerChrysler says its costs ranged from \$1,331 in New York, birthplace of Certificate of Need, to \$3,519 per person in Wisconsin, which has a very limited Certificate of Need law. [50] The studies report that states with Certificate of Need laws had costs 11% to 39% lower than states without such regulations. These studies conclude that, cumulatively, all three automakers' health care costs were 30% lower in states with Certificate of Need laws. [51]

The research methods of the automakers' studies are fraught with difficulties. First, the studies only look at eight states, some with Certificate of Need laws and some without, and those states with such laws enforce them in varying degrees. [52] Moreover, these states are all in the same general region, making meaningful statistical conclusions difficult.

Second, the studies fail to establish a link between Certificate of Need laws and the cost of health care benefits. Built into the report is the assumption that because the cost of health care for a certain segment of the population (auto company employees) in a few states is less than in a few other states, Certificate of Need laws that are merely intended to reduce health care costs actually do work. One condition is not necessarily related to the other, and unless a cause-and-effect relationship can be established, the statistics are meaningless in the discussion of Certificate of Need's effectiveness.

Certificate of Need advocates use other, even less reliable, research conclusions. One oft-cited study claims that open-heart surgery mortality rates are 20% lower in states with Certificate of Need regulations than in other states. [53] A 1988 study, however, concluded the opposite of the above study; that Certificate of Need laws actually work to increase in-hospital mortality. [54]

Not long after the Federal Trade Commission and Department of Justice released their report critiquing Certificate of Need programs, the American Health Planning Association (AHPA) published a response. In it they attempt to highlight the benefits of Certificate of Need laws. Following is a point-by-point look at the AHPA's response. [55]

Claim: CON is a useful market balancing tool.

Proponents of central planning say that in an imperfect and increasingly inequitable health care system, CON regulation is a flexible tool that, when used intelligently, helps protect the critical health care infrastructure that is essential to meeting both expected and unanticipated needs.

If history has demonstrated anything, it is that the state has a poor track record when it comes to economic planning and forecasting. Yet that is exactly what the state attempts to do when it decides on the "need" for a local health care facility. Moreover, Washington's Certificate of Need program is not really "community-based," because it disregards community input that does not fit with pre-set planning formulas. The AHPA's rationale is flawed because it proposes to solve problems created by government intervention with more government intervention.

Claim: empirical evidence shows substantial economic and service quality benefit from CON regulation and related planning.

The only source cited in this claim is a Journal of the American Medical Association article arguing that open-heart surgery mortality rates are 20% lower in states with Certificate of Need regulation. This is an isolated example that attempts to link the effects of regulation with a positive statistic. The empirical connection in this single instance is weak at best.

Furthermore, numerous studies show that Certificate of Need regulation has had zero or negative impact on the quality of health service. One specialist in Walla

Walla estimates that up to three people in the area die each year because a cardiac surgery center is not close enough. [56] State regulators denied a Certificate of Need to a local hospital that sought to open such a center.

Claim: CON regulation is one of the few practical planning tools available to policymakers.

The underlying premise here is that public policymakers need to be involved in health care facility planning. But do they? Bureaucrats and central economic planning inhibit private provider's ability to supply necessary services to the public at reasonable prices. Government management and the third-payer system have distorted the market, and the cost problems we see today are the results. The solution is to encourage greater consumer control and transparent pricing informed by unimpaired market inputs.

Central planners also use a volume and quality argument to justify Certificate of Need for tertiary services such as cardiac surgery, organ transplant, etc. The argument here is that by using Certificate of Need laws to concentrate volume at specialty hospitals, the quality of services provided there will increase.

This sounds attractive in theory, but in practice the evidence supporting the argument is weak. While Washington's JLARC study concluded "the research evidence is strong that higher volumes of certain surgical procedures leads to better outcomes," it admits that this is true only for some procedures and that not all evidence supports the conclusion. [57] The same report found that Certificate of Need might reduce the quality of kidney dialysis services by reducing access. [58] This point is of more than passing importance to kidney disease sufferers, to whom reduced access to reliable dialysis can prove fatal.

*CON limits are of more than passing importance to kidney disease sufferers, to whom reduced access to reliable dialysis can prove fatal.*

Some health care professionals have criticized the state's rationale for concentrating volume. Dr. Robert Johnson, a cardiologist in Walla Walla, once remarked that "our knowledge about how many operations have to be done by one surgeon to have good outcomes has changed since [the state placed CON regulations for volume]. It's not nearly as many as was thought to be the case." [59]

Attempting to control the geographic distribution of health care services is another way central planning reduces patient access. The government has offered special certification for regional centers of excellence in a given field so long as those institutions perform a certain number of procedures in a year. This produces two problems. First, the requirement concentrates certain health services in one geographic area, thereby creating a hardship for people who live out of the area. The added distance increases both patient cost and risk. Second, a facility that has to perform a certain number of procedures in a year to maintain government-sanctioned preferential status may be inclined to perform unnecessary procedures simply to boost its numbers.

#### **VIII. Policy Recommendations**

Washington Policy Center's recommendations for addressing the Certificate of Need issue are presented below in priority order, beginning with the most effective and far-reaching proposal for reform. Next, two alternatives are given that would ease the regulatory burden the program places on the state's health care system.

##### **1. Repeal the Certificate of Need Law.**

Washington should follow the example of the 14 other states that have repealed their Certificate of Need laws. Disaster did not follow repeal in those states, and it will not follow repeal in Washington. The 1999 JLARC study lists repeal a key policy option. Evidence cited by Certificate of Need proponents as justifying these complex regulations is inconclusive at best, and abundant evidence to the contrary shows that Washington's Certificate of Need law likely does more harm than good. The Certificate of Need law distorts important market signals that indicate when and where new health services will be needed. More than 30 years of experience shows that the Certificate of Need law acts as an impediment to achieving cost-effective, community-responsive health care.

##### **2. Significantly Scale Back the Certificate of Need Law.**

Short of outright repeal, many states have scaled back their Certificate of Need laws so they cover only a few types of facilities or only kick in at a higher expenditure threshold. For example, CON

requirements should be eliminated for nursing homes to help meet the needs of an aging population. Partial repeal could be adopted as the first step to completely phasing out Washington Certificate of Need law.

Alternatively, the legislature could enact partial repeal with the intention of leaving a limited number of health services permanently under the control of Certificate of Need regulation. In both cases, partially repeal would allow time for the legislature to review the results. Lawmakers may find the Certificate of Need law works best when it applies only to a few medical specialties, while leaving most providers free to open new clinics, hospitals and nursing homes as health needs change in the community.

### **3. Authorize the Certificate of Need Task Force to Investigate Thorough Reforms.**

In early 2005 the legislature created a special task force to examine the Certificate of Need program. The task force began meeting later that year and is charged with making recommendations on ways to improve and update the program. Even those who support the Certificate of Need program tacitly admit it is not lowering health care costs: "We need to look at the Certificate of Need program as a health planning process in relation to escalating health care costs." [60]

Unfortunately, the task force was hamstrung from the outset. In conducting its study the task force is required to presume "that the services and facilities subject to certificate of need should continue to be subject to it." [61] Given this restriction, genuine reform is not possible. The legislature should expand the task force's authority so its members can conduct a thorough investigation of the Certificate of Need program. The task force could then assess the program's actual performance compared to stated goals, review the experiences of other states and propose practical reforms that will improve health care access for Washington residents.

### **IX. Conclusion - Certificate of Need Represents the Failure of Government Central Planning**

Three decades of experience has supplied ample evidence that Washington's Certificate of Need program has not worked as its creators intended. The law has not controlled costs, improved quality or increased access to health care. In fact, the law has had the opposite effect, actively blocking citizens' access to health care choices and to modernized health care facilities.

There is, however, abundant evidence the process has become arcane and politicized, and that medical organizations holding Certificates of Need use the process to keep competitors out of their area. An indication of this effect is the program's use of non-medical criteria, like an applicant's record in providing charity care or the existence of any civil rights complaints, in deciding whether to approve a Certificate of Need.

In practice, Washington's Certificate of Need law is not about improving health outcomes for citizens, it is about controlling access to health care. The state's Certificate of Need process is more important in determining how and where patients will be treated than the decisions made by doctors and hospital administrators. This point is illustrated by an observation of economist F.A. Hayek, "The power that a millionaire, who may be my neighbor and perhaps my employer, has over me is much less than that the smallest functionary possesses who wields the coercive power of the state, and on whose discretion it depends whether and how I am able to live or work." [62]

When health care organizations are allowed to compete with each other in a system that functions more like a normal market, consumers of health care win because there are both short- and long-term incentives for providers to innovate and grow more efficient. Robust competition builds a more nimble, community-responsive and consumer-centered system that readily adapts to changing needs. Inflexible planning and regulatory structures that keep competitors out cannot achieve this. The program's record indicates the Certificate of Need law no longer serves the public interest, if indeed it ever did. The stated purpose of the program is to foster a health care system that controls costs and meets changing conditions. Yet, to succeed such a system requires the very flexibility the Certificate of Need is designed to prevent. In a state experiencing rapid growth and demographic change, the Certificate of Need law prevents providers from adapting to the changing health needs of the community.

*CON laws actively block citizens' access to health care choices and to modernized health care facilities.*

### **Three Case Studies**

#### **1. A Flawed Process**

When the Department of Health decided in June 2005 that Issaquah did not need a new hospital, it did so based on the proximity of three other hospitals. "If you put a point in the center of Issaquah, there are three hospitals within 12 miles," said Laurie Jinkins, assistant secretary of health-systems quality assurance for the state Department of Health. [63] She was referring to Overlake Hospital in Bellevue, Group Health Cooperative in Redmond, and Snoqualmie Valley Hospital. A closer look, however, reveals flaws in the state's decision.

First, Group Health Cooperative is not open to the general public. Only members of the Group Health insurance network can use Group Health services. Yet the state makes little adjustment for that fact in its calculation of hospital bed availability and need.

Second, Snoqualmie Valley Hospital has what one article called "a troubled past." It is a hospital that has been plagued "by maintenance mishaps, two closures and eroded credibility." [64] But it is a hospital with twenty-eight beds, and in spite of its demonstrated unreliability, its poor reputation and many people's refusal to go there, the state included those beds when calculating bed availability and medical need.

This issue raises serious questions about the Certificate of Need determination process. Proponents of Certificate of Need planning tout the program as being "community based" or "community oriented," but in this case the process ignored two important community factors that influence the availability of hospital services to the public. An inflexible bureaucratic structure was unable to take account of legitimate local concern.

### **2. Stifling Competition Does Not Lower Costs**

In May 2005, the Puget Sound Business Journal reported that a "statewide turf war" had erupted amongst providers of kidney dialysis, one of the many services covered by Washington's Certificate of Need law. Providers had filed more than a half dozen appeals regarding various dialysis station proposals. "I've never seen the number of appeals as high as now," one industry consultant observed. [65]

Several dialysis providers sought state permission to open new facilities or expand existing capacity. Rival companies fought Certificate of Need approvals as a way of preventing another provider from encroaching into their region. The business journal reported, "Appeals are becoming more common, as competition in the industry has surged with new market entrants." [66]

So what is the effect of hindered competition? Higher prices. "Private carriers used to pay \$200 and \$300 per treatment," remarked Palmer Pollock, a planning administrator with Northwest Kidney Centers, "now it's more than \$1,000." Instead of reducing cost, as Certificate of Need laws are intended to do, kidney dialysis prices have increased by 330% - 500%. [67] This case shows how the Certificate of Need law not only fails to constrain rising health care costs, it actually puts upward pressure on the price of certain health services.

### **3. Ignoring Community Input**

In the 1980s, the residents of Putnam County, Georgia, ran headlong into state Certificate of Need regulators. As their federal Representative reported to Congress:

"[T]he citizens of Putnam County are proud of their 20-year-old community hospital. They built it with local funding, without using any Federal Hill-Burton funds, and they still support it locally. They are proud enough to have recently approved a 1-cent sales tax to renovate the facility. They are not seeking an expansion. The hospital has always had 50 beds, and that's what they propose to maintain.

"However, when Putnam County authorities went to the State health planning agency for the required approval under the certificate-of-need program this year, they ran into unexpected trouble. The agency looked over the request for the locally funded hospital improvements and decided to deny it - unless the hospital eliminated ten beds."

The state refused to budge and local health officials were forced to comply. Growth projections indicated that eventually all 50 beds would be needed, but the state insisted that ten of the beds be dismantled. They did so in spite of the fact that eliminating ten beds would reduce the number of nursing students the hospital could enroll, at a time when the country faced a shortage of nurses. Regulators also ignored the tremendous cost the community would incur later when hospital authority had to add back those ten beds.

This case shows how the centralized Certificate of Need process favors state-level regulators who insist on enforcing their decisions, regardless of the well-reasoned protests of local leaders.

## **Appendix**

### **Description of the Certificate of Need Process for Hospital Beds**

Following, in shortened form, is a description of the steps an applicant must take in requesting a Certificate of Need to build a new hospital or to add beds to an existing facility. Together, these steps represent one phase of a much larger process.

#### A. Develop Trend Information on Hospital Use

Steps 1 through 3: The hospital bed need determination begins with compiling historical use data—that is, how many days patients spent in hospitals based on types of treatment. (The state makes a distinction between time spent in a hospital for physical and psychiatric treatments. The need determination for psychiatric hospital beds is a separate process within the State Health Plan.)

Step 4: The state uses a ten-year history of hospital use rates to determine historical trends.

#### B. Calculate Bed Need Forecasts

Steps 5 and 6: Each of Washington's hospital planning area's (how the state divides the population of large areas into geographic units for planning purposes) hospital use rates are computed. At a minimum, two age blocks need to be considered: people age zero to 64 and people over 65. Age groups may be divided further.

Step 7A: The state forecasts each hospital planning area's use rates. It does this based on historical trends and projections made by the Office of Financial Management. The forecast is done for a target year, which varies. It can be as little as five or six years. [69] Moreover, the trends are arranged according to age group. Once determined, these trends are adjusted up or down, in proportion to the trend of either the statewide ten-year trend or the specific planning area's ten-year trend.

Step 7B: This is an alternative to Step 7A. In planning areas where a Health Maintenance Organization is present, adjustments must be made to factor in HMO enrollees. These adjustments are necessary because HMOs can control where their enrollees go for hospital care.

Steps 7B.1 through 7B.3: These steps serve to illustrate and correct skews created by HMO enrollment in a hospital planning area.

Steps 8 through -10: Here the bed need forecasts begin to take shape. Trend-adjusted use rates (see Steps 7A and 7B) and projected population are used to determine total forecasted patient days. Forecasted patient days are then distributed to hospital planning areas based on market share and the use of out-of-state hospitals. Average occupancy standards are then used to determine each planning area's bed need.

#### C. Determine Total Hospital Bed Need Forecasts

Steps 11 and 12: The non-psychiatric bed need forecasts calculated from this process are added to the psychiatric bed need forecasts (calculated in a separate process) to determine overall bed need for all hospital services. Any necessary adjustments are then made—for example, population adjustments, use rates, market shares, and shifts in occupancy rates.

It is important to note that these processes outlined here are only part of a much larger process for building a health care facility. These regulations are above and beyond standard county and city building permits, land use requirements, Growth Management limits, environmental impact statements, zoning regulations, building codes, construction review applications and public health standards. Naturally, these additional regulations are strictest for hospitals. Other regulatory factors applied to hospitals, in addition to Certificate of Need, include the following. [70]

**Additional Requirements**

Licensure and Physical Plant Requirements

- " Finishes (carpet, tile, wall covering)
- " Heating and ventilation system
- " Hot water system
- " Medication handling
- " Nurse call system
- " Room size, furniture & equipment
- " Shower and toilet fixtures

Fire / Life Safety Requirements

- " Automated sprinkler system
- " Electrical generator system
- " Fire alarm system
- " Fire / life safety structural design
- " Life support system
- " Medical gas system
- " Smoke control system

Standards Adopted by State Building Code Council

- " 2003 International Building Code
- " 2003 International Fire Code
- " 2003 International Mechanical Code
- " 2003 International Plumbing Code
- " Barrier-free requirements

- " National electrical code
- " Washington state energy code
- " Washington state ventilation code

These regulations are important to protecting public health and safety, and there is no suggestion that this requirement should be loosened or repealed. The purpose here is to show that the lengthy and complicated Certificate of Need process is imposed in addition to a long list of existing requirements.

#### **About the Author**

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- [1] "State and County Quickfacts," United States Census Bureau, Washington, D.C., at [www.quickfacts.census.gov](http://www.quickfacts.census.gov), accessed December 20, 2005.
- [2] Citizens Research Council of Michigan, "The Michigan Certificate of Need Program," February 2005, p. 1, Lansing. See [www.crcmich.org](http://www.crcmich.org).
- [3] Robert James Cimasi, "Duped by Cries of Duplication: The Failure of the Certificate of Need Regulations," April 2002, p. 1. Article accessed at the American Association of Ambulatory Surgery Centers website, [www.aaasc.org](http://www.aaasc.org) on 19 December 2005.
- [4] Legislative History of the 1972 Social Security Act Amendments, federal Social Security Administration, at [www.ssa.gov](http://www.ssa.gov). The provision reads, "The Secretary may withhold or reduce reimbursement amounts to providers of services under title XVIII for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, or other expenses related to capital expenditures for plant and equipment in excess of \$100,000, which are determined to be inconsistent with State or local health facility plans." p. 3.
- [5] National Health Planning and Resources Development Act (NHPDA) of 1974, Section 2(a)(1), see Public Law 93-641.
- [6] *Ibid.*, Section 1523(a)(5).
- [7] *Ibid.*, Section 1612(b)(1).
- [8] *Ibid.*, Section 2(a).
- [9] *Ibid.*, Section 2(a)(4).
- [10] Terree Wasley, "Certificates of Need: Poor Health Care Policy," Mackinac Center for Public Policy, Mackinac, Michigan, 1993.
- [11] Michael D. Tanner, "Ending the CON Game," The Heartland Institute, Chicago, 1996.
- [12] Source of chart data is, Citizens Research Council of Michigan, "The Michigan Certificate of Need Program," February 2005, p. 3. The figures include the District of Columbia.
- [13] State of Washington, Joint Legislative Audit and Review Committee (JLARC), "Effects of Certificate of Need and Its Possible Repeal," January 8, 1999, p. 1.
- [14] Revised Code of Washington 70.38.015.
- [15] Application figures cover the period August 27, 1971 through July 7, 2005, "Certificate of Need Action Log," Office of Certificate of Need, Washington Department of Health, July 7, 2005.
- [16] Mike Norbut, "Cutting through the CONfusion: Movement to Relax the Limits," American Medical News, February 7, 2005.
- [17] Washington Administrative Code 246-310-010.
- [18] Washington Administrative Code 246-310-160.
- [19] Washington Administrative Code 246-310-150.
- [20] Washington Administrative Code 246-310-560.
- [21] Washington Administrative Code 246-310-610. The appeal timelines are governed by the Administrative Appeals Act, Revised Code of Washington 34.05.

- [22] Andree Brooks, "Walk inside, have surgery, but is it safe?", *The New York Times*, June 14, 2005.
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THE MACON SERIES

NOVEMBER 2005



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**CERTIFICATE-OF-NEED LAWS**  
**IT'S TIME FOR REPEAL**

Dr. Roy Cordato

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NATHANIEL MACON RESEARCH SERIES  
NUMBER 1

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*John Locke*  
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THE MACON SERIES

## THE MACON SERIES

*This report on certificate-of-need regulation is the first in a series of annual research papers from the John Locke Foundation devoted to explaining the principles of free markets and applying them to current controversies in North Carolina. The Nathaniel Macon Research Series was created with the generous financial support of David R. Carr, Jr. of Durham, in memory of his friend and business partner George W. Brumley, III, who was a strong believer in the crucial role that robust, unfettered markets play in advancing human progress and promoting a free society. The Macon Series will examine closely the fiscal and regulatory policies of the state and whether they help or hinder individuals seeking to create or expand businesses and economic opportunities in North Carolina. The series is named after Nathaniel Macon, a North Carolinian and close political ally of Thomas Jefferson who served as Speaker of the House and U.S. Senator during the first few decades of the American Republic. Macon frequently argued, "that government is best which governs least."*

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### WHAT'S WRONG WITH THIS PICTURE?

Imagine an economic system where market competition was viewed as a wasteful activity that needed to be discouraged or even prohibited by government. In such a system, for example, if a Chinese immigrant family wanted to open a restaurant, it would first have to go to a government commission that would survey the economic landscape for Chinese restaurants to determine if there already might be "enough" such eateries in the area. The commission might have a formula that would look at data regarding how many Chinese restaurants exist per 100,000 or 50,000 or 25,000 in population; how many of those are strictly take-out restaurants and how many are eat-in or "sit-down" restaurants; and among those that are sit-down style, how many feature buffers and how many are strictly order-from-menu. The formula might also consider variations in price from restaurant to restaurant to determine how many are serving lower-income families and how many might be targeted to the gourmet Chinese food market.

After going through all this – a process that might take several years – the commission would then decide whether this particular Chinese restaurant is "needed" in the area. If it were not, this immigrant family would then be sent packing to decide on another way of earning a living. Or, it might be suggested that they try some other area where it has been determined there are too few Chinese restaurants to adequately serve the existing population.

If it is determined that, yes this community indeed does "need" one more Chinese restaurant, a "certificate" would be issued to the immigrant family. It would state that a restaurant of this type and size is "needed" and that the family has permission to set up shop. But of course the restaurant would have to be built to the exact specifications described in the original proposal and that was ultimately approved. It may not be able to offer take-out service if there are al-

ready “enough” take-out restaurants in the area. It would have to be built only to accommodate a certain number of tables because any more or any less would not fit the need as determined by the formula. The menu would have to be approved, because if the restaurant were also going to serve non-Chinese foods such as pizza or hamburgers – for those who might not like Chinese food – that would fall into a different category and those menu items would have to be passed through another formula and another process.

Most people would look at such a system and think “this is crazy, only a Soviet-style central planner could be happy with such a bureaucratic nightmare.” Besides, we all understand it is competition that makes the consumers in the marketplace better off. Competition brings lower prices, more convenience, better quality, new technologies and innovations, and so on.

The system as described above will have its beneficiaries. Government workers charged with running the system clearly can do well because of its existence. But beyond this, what about existing restaurateurs who had already received one of these highly valued certificates and were operating a flourishing business? Wouldn't

*Most people would look at such a system and think this is crazy, only a Soviet-style central planner could be happy with such a bureaucratic nightmare.*

they like the idea that the local government had an entire division devoted to protecting them from competition?

Wouldn't it be nice

to not have to worry about customers being taken by some upstart Chinese restaurant with lower prices or fancier foods on its buffet? Sure, restaurant customers would probably be better off if anyone who wanted to could simply start a new restaurant, but people aren't aware of what they are not getting. Some customers might

look around and say “gee, the town already has a couple of Chinese restaurants and there’s never a wait to get in, so why is there a need for another one? Certainly a new one would be wasteful.” Of course this would be said without knowing what a new restaurant would be like, what menu items it might offer, what prices it might charge, etc. Because people don’t know what they don’t know, even the consumers, who are always hurt by monopolies, might end up supporting this system.

#### **THE REALITY OF CERTIFICATES FOR MEDICAL CARE**

The system described above is exactly the kind of system that North Carolina and 34 other states have with respect to medical-care facilities and equipment. If you are a health care entrepreneur and you want to do anything from adding a new wing or extra beds to an existing hospital, to opening an office that offers MRI, X-ray or other services, you need a “Certificate of Need” (CON) from the state. The function of CON is summarized as follows:

*“The North Carolina Certificate of Need Law prohibits healthcare providers from acquiring, replacing, or adding to their facilities and equipment, except in specified circumstances, without the prior approval of the Department of Health and Human Services...The law...limits unnecessary health services and facilities based on geographic, demographic and economic considerations... All new hospitals, psychiatric facilities, chemical dependency treatment facilities, nursing home facilities, adult care homes, kidney disease treatment centers, intermediate care facilities for mentally retarded, rehabilitation facilities, home health agencies, hospices, diagnostic centers, oncology treatment centers, and ambulatory surgical facilities must first obtain a CON before initiating development. In addition, a CON is required before any upgrading or expansion of existing health service facilities or services.”<sup>(1)</sup>*

If this sounds like the kind of central planning one might find in a socialist economy – it is. In North Carolina, the central planning authority is known as the Health Planning Development Agency,

part of the North Carolina Department of Health and Human Services. The role of this agency is to plan economic activity provided by medical-care facilities. This is done down to the most minute detail, circumventing the most basic function of private decision-making in a free enterprise system, i.e., the allocation of resources based on entrepreneurial insight and risk taking.

The purpose of the Health Planning Development Agency in implementing CON is to "develop policy, criteria, and standards for health service facilities planning; [ ] conduct statewide registration and inventories of and make determinations of need for health service facilities, health services as specified [in the statute] and equipments as specific [in the statute], which shall include consideration of adequate geographic location of equipment or services; and develop a State Medical Facilities Plan." The Agency also has "the authority to review all records in any recording medium of any person or health service facility subject to agency review under these articles which pertain to construction and acquisition activities, staffing or costs and charges for patient care, including but not limited to, construction contracts, architectural contracts, consultant contracts, purchase orders, cancelled checks, accounting and financial records, debt instruments, loan and security agreements, staffing records, utilization statistics and any other records the Department deems to be reasonably necessary to determine compliance..."<sup>(2)</sup>

North Carolina's Certificate-of-Need Law is, with few exceptions, an all inclusive and all intrusive blueprint for state government control of all supply and pricing decisions with respect to the provision of institutional health care facilities (see Appendix for a complete list of CON-regulated services in North Carolina and other states). The process that a potential hospital, nursing home, clinic, doctor's office or other supplier must go through to receive a CON is tedious and potentially very long. Depending on the number of reviews, the process can take anywhere from 90 days to over two years. If a denial

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is appealed to the state Court of Appeals, the process can go well beyond this two-year period. As of the Summer of 2005, the CON approval process for the expansion of Good Hope Hospital in Harnett County North Carolina has been dragging on for over four years. The law has fostered a contentious political and legal battle between Good Hope and other hospitals in the area that also involves Harnett County, the Town of Lillington and the City of Dunn. While this political warfare is taking place, costing millions of dollars, the people of the area could be benefiting from additional health care facilities.

**CON Process:**

<b>Task</b>			<b># Days to receive feedback</b>
<b>Submit letter of intent</b>			<b>0</b>
<b>Review period begins</b>			<b>0</b>
<b>CON Section makes decision</b>			<b>90-150</b>
<b>Denied / Approved =&gt;</b>	<b>Petitions allowable for 30 days</b>		<b>120-180</b>
	<b>Judge makes recommendation =&gt;</b>	<b>CON Section makes final decision</b>	<b>120-450</b>
	<b>Denied/Approved =&gt;</b>	<b>NC Court of Appeals</b>	<b>Indefinite?</b>

Source: Compiled by author using information from <http://facility.services.state.nc.us/conpage.htm>.

An April 2005 article in the *Triangle Business Journal* tells the story of a partnership of three neurologists who have spent three years and over \$250,000 in an attempt to set up an MRI imaging center

in Garner, North Carolina. In this case the CON process has led to a battle between these doctors and hospitals in the region. This is not a healthy economic contest among suppliers of a service attempting to better serve health care customers, but rather a battle to win the favor of a government bureaucracy in an attempt to gain or keep a monopolistic cartel. Out of complete frustration, this group of neurologists is giving up. Competition for MRI services is denied and potential patients in Garner and the surrounding areas are deprived of taking advantage of the alternative that this physicians group was attempting to offer.<sup>(3)</sup>

It is quite clear that all important aspects of the production, distribution, and sale of health care services in North Carolina, and most other states, have been removed from the competitive free enterprise system and placed under the authority of a command-and-control government bureaucracy. And like all other bureaucracies, it promotes factionalism and division and allows some groups and institutions to suppress the activities of others. The market is run by government fiat rather than entrepreneurial insight and patient preferences.

#### **HISTORY, JUSTIFICATION, AND APPLICATION OF CON**

The origins of CON in North Carolina, and many of the other states that have such a system, rest in a long since repealed federal government mandate. In 1974, Congress passed the National Health Planning and Resources Development Act. The Act stated that in order to receive federal funding from programs like Medicare and Medicaid, new health care facilities, and additions to existing facilities, needed approval from a state agency established to issue certificates of need. All states were told to have such programs in place by 1980.

This was seen as a way of controlling health care costs. At the time, reimbursements for services were being made on the basis of

costs of production. It was thought that facilities were being built and equipment was being purchased unnecessarily simply because the hospitals knew the facilities would ultimately be paid for through increased fees. In a market setting where health care providers need to compete for cost-conscious purchasers of services, even if those purchasers are insurance companies, higher costs cannot simply be passed along in higher prices. New facilities would be built or new equipment would be purchased only if the market prices for the services that would be generated could justify the added costs. As with any business, expansions would be made only if it was thought they could be justified by actual demand. This is what entrepreneurship is all about: spotting actual or potential unfilled demand and organizing resources in new ways in order to meet it. If the demand isn't there, losses will be incurred and plans would have to be revised.

The government payment system at the time did encourage inefficient investment because it took the risk out of the process. Costs were recouped regardless of any failure to accurately estimate demand. Indeed the so-called "cost plus" system of reimbursement took away the need to consider future demand at all. The result was a classic case of an initial government intervention into market decision-making – in this case the Medicare and Medicaid programs – creating distortions of its own, which in turn are used to justify additional interventions: the CON program. As is typical, the new interventions lead to their own set of problems.

In 1987 Congress repealed its mandate and stopped subsidizing states that implemented it. This came after the federal government abandoned its cost-based reimbursement system and switched to paying a predetermined amount based on the kind of treatment. Since that time, 15 states have dropped their CON program, allowing for competition. North Carolina is one of 35 states, plus the District of Columbia, that continues with centralized planning of the health care facilities market.

Although cost containment, as noted, was and continues to be the primary justification for CON, there are other reasons given for keeping these laws in place. The most prominent are related to the provision of care for the indigent and include the arguments that.<sup>(4)</sup>

- Removal of CON will place a greater burden on the disadvantaged. The fear is that market forces will lead to certain segments of the population and those living in rural areas, being underserved.
- Removal will favor for-profit hospitals, which may be less willing to provide indigent care.
- Removal will lead to a proliferation of "low volume" facilities, which are associated by some with lower-quality care.

As an historical footnote, in the 1960s and early 1970s, prior to the federal mandate, more than 20 states had decided to implement CON laws independently, allegedly for cost-control reasons. According to Charles Gerena, writing for the Federal Reserve Bank of Richmond, these pre-mandate laws were implemented "in response to hospital operators who favored centralized health

planning."<sup>(5)</sup> This is consistent with the economics of CON, to be discussed later, which suggests that in reality, CON is a cartel enforcement device that protects

*North Carolina is one of 35 states, plus the District of Columbia, that continues with centralized planning of the healthcare-facilities market.*

incumbent providers from new entrants and competition. According to East Carolina University researchers Campbell and Fournier, "there are reasons to suspect that CON may have been adopted for other purposes...the states most likely to enact CON...were those with a highly concentrated hospital industry and increasing competitive pressures...hospitals were largely in favor of CON regulation, which is understandable considering that it protected them

from competition.”<sup>(6)</sup> Much like existing restaurant owners in our opening example, having a government bureaucracy whose goal is to protect your business from upstarts is a nice perk.

In reality, the continuation of CON regulations cannot be justified either theoretically or empirically. In fact, from the perspective of sound economics, the reverse is true. If one desired to devise a policy for any market whose purpose would be to reduce efficiency, raise costs and prices, and reduce product quality, the existing CON programs would be highly recommended.

#### **IF YOU LIKE OPEC, YOU'LL LOVE CON**

When it comes to crude oil, it is indisputable that the ability to raise prices and therefore energy costs, rests with the power to

*Ironically, for those who support CON laws, it is thought that medical-care markets operate in the exact opposite manner, that the way to keep costs down is to restrict the supply of medical facilities and equipment.*

restrict output and production. When President Bush met with Prince Abdullah of Saudi Arabia on April 25, 2005 to discuss high oil

prices, the question immediately turned to the Organization of Petroleum Exporting Countries (OPEC), which raises prices by restricting production. Saudi Arabia, the largest oil producer in the world and the leader of OPEC, is seen as having the power to expand production and bring prices down.

Ironically, for those who support CON laws, it is thought that medical-care markets operate in the exact opposite manner, that the way to keep costs down is to restrict the supply of medical facilities and equipment. For example, if one wants MRI services to be less expensive, we need to have fewer MRI machines; if we want hospital stays to be cheaper, then what is needed is fewer hospital rooms.

As pointed out by The National Academy for State Health Policy in describing CON regulations: "Efforts to control the supply of services are well demonstrated by state Certificate of Need programs, which seek to limit the acquisition and dissemination of substantial investments in technology and capacity. These limitations are imposed in an effort...to hold down the volume of services provided and the cost."<sup>(7)</sup> In fact though, it is just as wrong-headed to think that limiting the supply of health care equipment and facilities can reduce health care costs, as it would be to think that oil prices could be brought down with further reductions in oil production.

There is possibly no proposition in economics that is more accepted than the idea that if you want to reduce the cost of something, you foster an environment that encourages open competition and entrepreneurship and discourages monopoly. But the role of competition goes well beyond this. Rivalry among businesses – and health care providers are no exception – stimulates new technologies and innovative and more efficient ways of delivering goods and services to

Rivalry among businesses – and health care providers are no exception – stimulates new technologies and innovative and more efficient ways of delivering goods and services to customers.

customers. Existing providers continuously have to keep their costs low and their products desirable in order to fend off potential

competitors looking for an opportunity to earn profits. These potential competitors, like the neurologists discussed previously who wish to provide MRI services, are always looking for ways to outperform existing providers. According to the *Triangle Business Journal*, these doctors had planned to offer greater convenience, newer technology, and lower prices than existing MRI facilities, which are predominantly owned and operated by full-service hospitals. They planned to locate in Garner, North Carolina, which has no MRI facilities,

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making these services more convenient to patients and other doctors in the community. Furthermore, according to Dr. Daljit Buttar, one of the neurologist/entrepreneurs who has been fighting for the right to compete, their plan was to charge lower prices than the hospitals and to offer a new technology that provided a better view of the body.

As noted, CON laws turn the simple economic truths about the relationship between competition and lower prices and higher quality on their head. Proponents of CON laws do not refute the economics by presenting an alternative economic framework that would



*What is and isn't excess capacity has to be determined in the marketplace and will be revealed through the system of profit and loss.*

explain why an actual free market in medical-care facilities and equipment would not behave as economic theory would predict. In-

stead they suggest that standard economics should not be used as the basis for analysis at all, even though what is being assessed is at the heart of what economic science is about – market price and output formation and the efficient allocation of scarce resources.

For example, The American Health Planning Association (AHPA), in criticizing a recent report by the Federal Trade Commission (FTC), disparagingly notes that the FTC grounds its opposition to CON laws in “orthodox economic doctrine.” The AHPA suggests that to rely on standard economic theory, as opposed, I presume, to some non-orthodox economic theory or possibly some other social science, is to ground the analysis in “an article of faith.”<sup>(8)</sup> This would be comparable to complaining that much of medicine and the analysis of patients’ conditions by doctors is grounded in “orthodox” theories of biology and human anatomy.

In large part, the idea that increased supply leads to higher prices and costs stems from a basic premise that is clearly false; namely that

service duplication within a geographical area (defined by government planners) is inefficient and therefore cost enhancing. In justifying North Carolina's law, it is stated that "the costly proliferation of *unnecessary* health service facilities results in *costly duplication* and *underuse* of facilities, with the availability of excess capacity leading to *unnecessary* use of expensive resources and *over utilization* of health-care services"<sup>(9)</sup> [emphasis added]. First, note the presumptuous and paternalistic attitude of the legislators formulating this statement. They claim to know better than health care consumers, their doctors, and facility operators, how "necessary" facilities are and that these market participants are "overutilizing" the health care that is available to them.<sup>(10)</sup> It should also be noted that the utter confusion of this statement is demonstrated by the fact that in the same sentence, it claims the free market somehow leads to both "the *underuse* of facilities" and the "*over utilization* of healthcare services" (huh?).

But more importantly, in a fundamental sense, the statement is proclaiming that monopoly is good. Facility duplication is at the heart of competition. Indeed, the definition of a monopoly market is one where there is no duplication. And this is why customers in monopoly markets lose. They are denied the option of turning to others who are providing "duplicated" services when the monopoly providers act like monopolists. Consider once again our team of neurologists. Would there be "excess MRI capacity" if they were allowed to enter the MRI market in Wake County? Apparently, some state bureaucrats, who are not market participants themselves, believe there would be. But the concept is meaningless. For example, because many Chinese restaurants, at a point in time, have empty tables, or some movie theaters have empty chairs, it doesn't mean there is inefficient excess capacity of restaurants or theaters. The new MRI facility would lead to more choice for patients and more competition for their health care dollars. Indeed, at the lower prices that could be generated, people who might forgo MRI exams for less expensive, but also less effective methods of diagnosis, may be able to take

## it's time for repeal


### CERTIFICATE-OF-NEED LAWS

advantage of the more advanced technology. What is and isn't excess capacity has to be determined in the marketplace and will be revealed through the system of profit and loss. Certainly there is no way for a health care central planner to second-guess the correct result.

#### *The Evidence on CON and Costs*

Not surprisingly, the evidence matches the economic theory. Since the 1980s when states were set free from the federal requirement to have CON laws, numerous studies have examined the change in health care costs as states eliminated their laws. If CON were "working" as advertised, then one would expect to see a rise in health care costs when the laws were eliminated. But in fact this is not the case. One of the most recent and widely referenced studies was written by Duke University Professors Christopher Conover and Frank Sloan and published in 1998 in the *Journal of Health Politics, Policy, and Law*.<sup>(11)</sup>

Their results are consistent with "orthodox" economics. Output restrictions lead to higher, not lower costs, and higher profits for existing providers. The authors point out that for hospitals, CON laws resulted in a 2 percent reduction in bed supply *and* "higher costs per day and per admission, along with higher hospital profits," exactly what economic theory would predict. The study did find a mod-



Overall, the study found that CON was responsible for a 13.6 percent increase in per capita spending on personal health care services.

est reduction in per capita "acute care" spending, which it attributed to CON laws. Interestingly, the study "was unable to detect a statistically significant

effect of removing CON on these same expenditures." But overall, the study found no decrease in per capita health care spending attributable to CON.

An earlier study showed even more dramatic results. This study examined data through 1982 and found that CON was associated with a 20.6 percent increase in hospital spending and a 9 percent increase in spending on other health care. Overall, the study found that CON was responsible for a 13.6 percent increase in per capita spending on personal health care services.<sup>(12)</sup>

Over the last two decades, the Federal Trade Commission has done several studies on the impact of CON laws, both nationally and for specific states. The FTC's consistent conclusion can be summarized in the language from its most recent study released jointly with the Department of Justice in July 2004. "The Agencies believe that CON programs can pose serious competitive concerns that generally outweigh CON programs' purported economic benefits. Where CON programs are intended to control health care costs, there is considerable evidence that they can actually drive up prices by fostering anticompetitive barriers to entry."<sup>(13)</sup>

In 1989, similar testimony was given to the North Carolina Goals and State Policy Board by FTC staff. The staff testified that "evidence does not support the view that Certificate of Need regulation reduces the costs of providing healthcare services...consumers would most likely be better served if CON regulations were removed."<sup>(14)</sup> As one study reports, "in researching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering healthcare costs."<sup>(15)</sup>

### *CON as a Hidden Health Care Tax*

While the discussion to this point has focused on the economics of CON, it should be pointed out that there are other fallback arguments for these regulations that relate to the provision of care to the indigent. Oddly enough, the arguments from this perspective actually contradict the "cost saving" case for CON. The argument is that entry restrictions, and the higher prices and profits that go along with them, are necessary to induce providers to provide free indigent

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care. As summarized in a study by Campbell and Fournier, "CON policies have...been pursued with the implicit aim of 'cross subsidization,' that is, regulators have used their power to issue licenses and restrict competition in order to create an incentive to hospitals to provide high levels of care to the indigent population."<sup>(16)</sup>

What this means is that CON laws are used to create a hidden tax. The cost of health care and the profits to health care providers are purposely kept high by granting monopoly privileges. It is then expected that these excess profits will be used to provide free health care to the indigent. Health care customers are forced to pay a premium created by CON laws and the proceeds from this premium are used to pay for indigent care. If nothing else, this is dishonest. If a social and political goal is to see to it that those who cannot afford health care have their needs taken care of, then the costs of that policy should be up front and explicit. This is the only way the electorate can make informed decisions regarding public policy. If it is deemed that those who are paying for health care services should bear the burden

*If CON laws are being used to hide this tax from the electorate, then not only are they inconsistent with sound economics, they are also inconsistent with an open and democratic political process.*

of also paying for care given to the indigent, then an explicit excise tax should be placed as a line item on all health care invoices,

and CON laws should be abolished. If CON laws are being used to hide this tax from the electorate, then not only are they inconsistent with sound economics, they are also inconsistent with an open and democratic political process.

Another way in which CON imposes a hidden tax on the health care system relates to the resources hospitals and other health care entrepreneurs must devote to obtaining the certificate. The process of obtaining a CON is not only time consuming but expensive. As

noted previously, in the case involving the group of neurologists from Garner seeking a CON for MRI equipment, over \$250,000 was spent on what was ultimately a futile effort. This is not money that was spent on equipment or improving neurological services to patients. It was money spent to gain permission from the state to offer services to patients. Like any other tax, it is an additional cost of doing business that ultimately raises health care expenses across the board. This \$250,000 is just one instance from many battles to gain CON "licenses" that are continuously being fought across North Carolina. As also mentioned previously, it has been reported that the effort by Cood Hope Hospital in Harnett County has cost in the millions.<sup>(17)</sup>

#### **HEALTH CARE POLICY: BREAKING THE CONSUMPTION/PAYMENT LINK**

Is health care over-priced? In many, if not most cases, the answer is yes. But this is not a problem that CON regulations can address. In fact, as argued previously, such laws are likely to contribute to the problem. The reason why health care may be overpriced is that, in most cases, what economists call "the consumption/payment link" is broken.

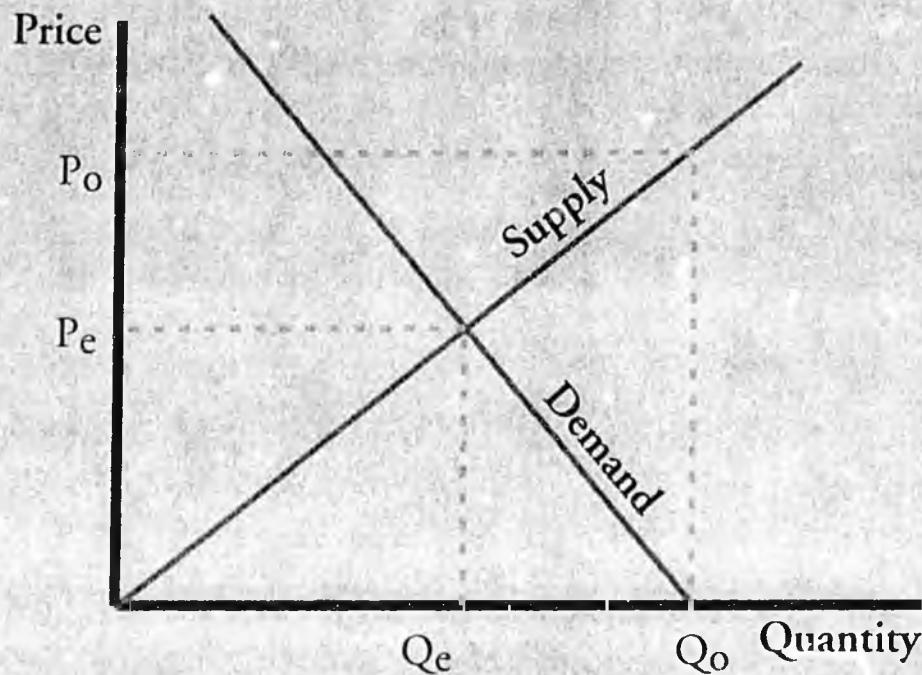
Because of government entitlement programs and the nature of modern health insurance, most people do not directly pay their own health care expenses. In 2002 over 84 percent of all personal health care expenditures were made by someone other than the person receiving the care.<sup>(18)</sup> Unlike the market for other goods and services, health care is consumed by the patient and, minus a co-pay or deductible, paid for by state and local government or by an insurance company operating a health care plan. Hence, the "consumption/payment link" that is typical of the clothing market, the computer market, or most other buyer/seller arrangements, is broken in the health care market.

***How is Health Care Like an All-You-Can-Eat Buffet or a Free Shopping Spree?***

This arrangement causes health care to be over-priced because it leads to health care being over-consumed. People will generally consume more of any product when the amount paid is unrelated to the amount consumed. Furthermore, they will consume relatively more of what would otherwise be the highest-priced or higher-valued options. This is why people tend to “over-eat” at all-you-can-eat buffets. It also explains why, if there are crab legs or sirloin steaks on this buffet, people will tend to consume relatively more of those items than the hot dogs or beans.

Imagine if a grocery store operated like health care. Instead of walking up and down the aisles seeing different prices for different food items and making tradeoffs between prices and different kinds of products, we were all on an employer-paid-for “food insurance” plan. Whenever we needed groceries, we drove to the local supermarket and paid a fixed co-pay at the door. Once inside, we could simply take all the food products “we needed.” As a food consumer, how might we behave? Would we take only “what we needed” or all that we could carry out? Would we go directly to the hot dogs and canned beans or would we find ourselves eating significantly more filet mignon and lobster? Clearly, the “purchase” of food overall and the proportion of lobster and high-priced cuts of meat relative to hot dogs and beans would increase. This would send the overall price of food and the “food insurance” premiums and co-pays through the roof. This is exactly what has been happening for decades in the health care market. [For a simple diagrammatical explanation of the economics involved in this phenomena see Diagram 1 on next page.]

DIAGRAM 1:  
Breaking the Consumption/Payment Link



The graph shows the extreme case when the product is consumed by one person and the payment is made entirely by a third party. In a typical market, price would settle at  $P_e$  and the amount consumed would be  $Q_e$ . This is "market equilibrium" where quantity and price offered by the supplier is equal to the quantity and price that is acceptable to the demander. This is not typical of health care markets. The graph also shows the result when the price to the consumer is zero. At zero price, the consumer will want to purchase not  $Q_e$  but  $Q_o$ . But the supplier will only be willing to bring forth this greater supply of health care services at a higher price. In the graph above  $P_o$  shows the amount the supplier would need to receive in order to bring forth this greater quantity of services. In health care markets, depending on how much deductibles and co-pays are, the quantity consumed will be somewhere between  $Q_e$  and  $Q_o$  and the price will lie somewhere between  $P_e$  and  $P_o$ .

***The Problem of Low Deductibles***

The fact that many plans have low deductibles with routine health care problems being paid by insurance, rather than only high-cost operations and catastrophic conditions, also fuels the costs of health care. In the 1940s, '50s, and '60s, most people referred to health care insurance as "hospitalization insurance." This is because insurance mostly covered high-cost health problems that required operations and stays in the hospital. The effect of what is now called "first dollar coverage" or near first dollar coverage, i.e., plans with very low deductibles, can be seen if we imagine the effects of auto insurance that not only covered damage from accidents, but oil changes and tune-ups as well. If people showed up for an oil change and showed the mechanic an insurance card, the service shop would clearly be less concerned about keeping the price competitive, and the car owner would be less concerned about getting the best deal. The prices of oil changes, tune-ups, etc., would be much higher than they are today.

***Isn't the Free Market Failing?***

The current consumption and payment arrangements are not the result of a free market for health care, but a failed set of government policies. As noted, most people do not pay directly for their own health care, but it goes beyond that. They don't even pay directly for, or even own their own health insurance policy, like they would with auto or homeowners insurance. Taxpayer-funded programs like Medicare and Medicaid pay nearly 45 percent of all health care bills.<sup>(19)</sup> The rest is mostly paid for by group health insurance policies that are owned by employers. For most types of insurance, such as auto, homeowners, and life, premiums are associated with the risks posed by the owners of the policy, i.e., those who are covered by the policy. The problem of over-consumption is tempered by the policy owner's desire to keep his or her premiums low. This market check is

not in place for health insurance. Those who are insured are not paying individual premiums for their insurance, and the amount being paid in premiums is not related to the risk associated with insuring individual policyholders. As noted, with few exceptions, there *are* no individual policyholders.

All the usual checks that would occur in a free market are missing. There are a number of reasons for this but the most important

*The current consumption and payment arrangements are not the result of a free market for health care, but a failed set of government policies.*

is related to the way health insurance is treated for income tax purposes. The tax code penalizes the individual ownership of health in-

insurance policies and encourages the ownership of group policies by employers. Since WWII, health insurance provided by employers is considered a tax-free benefit to the employee, while personally owned health insurance plans must be paid for with after-tax income.<sup>(20)</sup> This has led to very generous and expensive low- or no-deductible plans offered by employers. In many cases a tax-free dollar offered in the form of a low- or no-deductible health insurance benefit is more valuable to an employee than a taxable dollar offered in the form of wages. So we end up in a situation where public policy has led to both an over-use of health insurance and health care services.

The public policy answer to this problem is arriving, albeit tentatively and slowly, in the form of "health savings accounts" (HSAs), which were made legal as part of the Medicare Reform Act passed in 2003. The entire point of these accounts is to reconnect the consumption/payment link. These plans allow employers to offer high-deductible insurance plans to their employees, which have lower premiums. The employer then deposits a fixed amount each year into an individual HSA that is owned by the employee and where both the

amount deposited and any interest earned is tax exempt. The money in this account can be used to pay for expenses up to the deductible as well as other health care costs. In addition, any amount left in an HSA can be willed to the owner's heirs, who are not required to use this money for health care expenses. The important point is that any amount from this account that is not spent remains the property of the employee, to be used for either future health care problems, retirement income, or to make their children and grandchildren better off.

This approach reconnects consumption and payment for most routine health care related costs. A dollar spent on health care services now is a dollar that cannot be used later. As in other areas of income allocation, people will consider tradeoffs. By in part reconnecting the consumption/payment link, HSAs provide people with an incentive to be smarter and more cost-conscious health care consumers. In addition, this approach returns insurance to its original purpose: to manage risk of catastrophic medical expenses as opposed to being a form of "pre-payment" for routine medical services.

#### **CON AND THE IMPOSSIBILITY OF CENTRAL PLANNING**


As has been noted at several points throughout this paper, CON regulations are an attempt at complete central planning of investment in health care related facilities. The underlying premise is twofold. First is that individuals and companies acting in a free market will misallocate health care resources. As stated directly in North Carolina's CON law, "if left to the market place to allocate health service facilities and health care services, geographical maldistribution of these facilities and services would occur..." and "the proliferation of unnecessary healthcare facilities [will] result in costly duplication."<sup>(21)</sup>

The second premise behind the law, implied by all that the law empowers the state to do, is that the state, through centralized

bureaucratic allocation of health care investment, can improve on market results, and better serve the public's health care needs. The point here is that even if the first premise, as tenuous as it is, is accepted, there is no reason to assume that a large-scale intervention, such as authorized by CON laws, can do anything to improve the situation.

This second assumption ignores all that the economics profession has learned over the last 50 years regarding command-and-control methods of resource allocation and the central planning of both economies in general and specific markets within economic systems. All of the reasons economists typically give regarding why economic central planning fails, apply to CON regulations.

In a free market, resource allocation is driven by entrepreneurs who try to predict what consumer demand is and will be for the future. Before a physicians group invests in MRI equipment, for example, they would want to be sure the community of patients they serve would bring forth enough business to eventually make that investment pay off. They have powerful market incentives to get it right. If their market analysis is wrong, they lose money and their entire practice suffers.




*In a free market, resource allocation is driven by entrepreneurs who try to predict what consumer demand is and will be for the future.*

In other words, the best judges as to whether the service will be "needed" are the entrepreneurs and investors them-

selves. It is the profit-and-loss system that works to efficiently allocate investment and to provide the information necessary for making wise investments. In the absence of CON, these medical entrepreneurs would be operating in all aspects of the health care market. Hospitals will continuously re-evaluate their circumstances to determine if new birthing rooms are needed, or an expanded emergency room is nec-

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essary, or if a new helicopter evacuation unit would be worthwhile. The key is that, in each of these cases, they have a strong incentive to accurately assess the market and the community's "needs." If they can't, they lose money and must divert revenues and resources from other, more worthwhile parts of their operations.



*A good entrepreneurial decision is one that accurately assesses health care consumers' needs and survives the competitive pressures of the marketplace.*

CON laws substitute bureaucratic decision-making for the market's entrepreneurial assessments. The problem is that the govern-

ment decision-makers have no basis for gathering accurate market information and, furthermore, they have no incentive to make sure investments get made in the right places, at the right times, and in the right amounts. Unlike the case with private entrepreneurs, if their decisions prove to be wrong, there are no personal consequences borne by the planners responsible. In fact, there is no real way of determining after the fact whether or not a proper decision has been made. Whether or not a market decision makes economic sense is determined as part of the competitive economic process itself. A good entrepreneurial decision is one that accurately assesses health care consumers' needs and survives the competitive pressures of the marketplace. That is, it is a decision that satisfies consumer needs at least as well as, if not better than, existing and potential competitors.

For those who are granted membership in the CON-sponsored cartel, the real tests of the marketplace are foregone. In other words, the market forces that would ultimately determine whether a particular investment by a hospital, clinic, physician's practice, etc. truly served the needs of the community, are blocked. The bureaucrats that decide on CON do not, indeed cannot, actually determine whether

there is a need that will best be filled by a particular applicant because they are outside the market process that actually generates that information.

Economist Friedrich Hayek in his Nobel Laureate lecture, "The Pretense of Knowledge," argued that central planners, like those charged with determining who should and should not get to provide medical services, can only "pretend" to have the information necessary to make the kinds of decisions they claim to be making. At best, any determination of "need" by such planners will be arbitrary

*The bureaucrats that decide on CON do not, indeed cannot, actually determine whether there is a need that will best be filled by a particular applicant because they are outside the market process that actually generates that information.*

and will not reflect actual market conditions. At worst, these planners can become witting or unwitting tools of entrenched interests who wish to keep

competition out of the market. As University of Pennsylvania analyst Mark Pauly noted, CON programs "tended to be 'captured' or dominated by the hospitals they were intended to regulate, and that those hospitals used regulation to keep out competition."<sup>(22)</sup>

## CONCLUSION

Certificate-of-Need Laws in North Carolina and other states should be repealed. State governments should not be aiding and abetting monopolies or their formation, or acting as a cartel enforcement mechanism for established health care interests. This is especially true in health care markets, where competition, which is widely recognized by economists as **the** most effective tool for driving costs down, is sorely needed. It is competition that provides the incentives to discover new technologies and new efficiencies for delivering those technologies to patients.

The idea that in the area of health care services, free market competition can't work as a means of cost control, is not grounded in either economic theory or empirical evidence. Indeed, in areas where competition is allowed to flourish, such as optometry, the customer is well served with plenty of options and competitive pricing. Furthermore, believing also that CON laws and the bureaucrats that administer them can do a better job than the competitive market process, is not only wishful thinking, it is the economic equivalent of believing the Earth is flat. Somehow, legislators have convinced themselves we can have the results of open competition by creating monopolies – as Orwell said, love is hate and war is peace.

Health care provision around the world is controlled by varying degrees of government central planning. Consequently, all systems tend to be dominated by different forms of health care market malfunctions. In countries like Canada and Great Britain, there are long queues and bottlenecks for vital services and treatments. In the United States, there are problems associated with high costs and affordability. None of these countries allow free markets and open competition. Government command-and-control has failed; it is time to let the free market work.

## END NOTES

- (1) "North Carolina Division of Facility Services, Certificate of Need Section, Overview of CON Process," found at <http://facility-services.state.nc.us/conpage.htm>
- (2) North Carolina General Statute. 131E, Article 9, §175-190, found at [http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/ByArticle/Chapter\\_131E/Article\\_9.html](http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_131E/Article_9.html)
- (3) Lee Weisbecker, "Doctor claims state's CON rules favor hospitals," *Triangle Business Journal*, April 29, 2005.
- (4) Christopher J. Conover and Frank Sloan, "Does Removing Certificate of Need Regulations Lead to a Surge in Healthcare Spending?" *Journal of Health Politics, Policy and Law*, Vol. 23, No.3, June 1998.
- (5) Charles Gerena, "Putting on the Brakes," *Region Focus*, Spring 2004, Federal Reserve Bank of Richmond. Found at [www.richmondfed.org/publications/economic\\_research/region\\_focus/spring\\_2004/feature1.cfm](http://www.richmondfed.org/publications/economic_research/region_focus/spring_2004/feature1.cfm)
- (6) Ellen S. Campbell and Gary Fournier, "Certificate-of-Need Deregulation and Indigent Hospital Care," *Journal of Health Politics, Policy and Law*, Vol. 18, No. 4, 1993, p. 906.
- (7) Ellen Jane Schneiter, et. al. "Rising Healthcare Costs: State Health Cost Containment Approaches," National Academy for State Health Policy, June 2002, p. 4.
- (8) See "The Federal Trade Commission and Certificate of Need Regulations: An AHP Critique, January 2005, [http://www.ahpanet.org/Con\\_issues.html](http://www.ahpanet.org/Con_issues.html) and "Improving Healthcare: A Dose of Competition," a report by the Federal Trade Commission and the Department of Justice, 2004, [www.ftc.gov](http://www.ftc.gov). It should be pointed out that among economists "Marxist" and socialist economics is considered to be the most prominent of the non-orthodox or "heterodox" approaches to economic analysis. It will be argued below that CON are indeed grounded in fundamental principles of what is called "market socialism."
- (9) Article 9, Certificate of Need, p.1. As will be discussed at length below, health care services are over-utilized, but not as a result of "the open market" but interventions that distort the market.

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- (10) In the section below titled "The Impossibility of Central Planning" this will be referred to as "a pretense of knowledge" which is a term coined by Nobel Prize-winning economist Friedrich Hayek.
- (11) Op. cit. at note 6.
- (12) Joyce A. Lanning and Michael Morrissey and Robert Ohsfeldt, "Endogenous Hospital Regulation and its Effects on Hospital and Non-Hospital Expenditures," *Journal of Regulatory Economics*, Vol. 3, No. 2, 1991 as cited in Ibid.
- (13) "Improving Healthcare: A Dose of Competition," a report by the Federal Trade Commission and the Department of Justice, July, 2004, <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>
- (14) From FTC press release found at <http://www.ftc.gov/opa/2004/07/nc-con.txt>.
- (15) Patrick John McGinley, "Beyond Healthcare Reform: Reconsidering Certificate-of-Need Laws in a Managed Competition System," *Florida State University Law Review*, Vol. 23, No. 1, 1995.
- (16) Campbell ES, Fournier GM, "Certificate-of-need Deregulation and Indigent Hospital Care," *Journal of Health Politics, Policy and Law*, Vol. 18, No. 4, 1993. Abstract found at [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list\\_uids=8120351&dopt=Abstract](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=8120351&dopt=Abstract)
- (17) From conversations with reporters covering the story for *The Daily Record* of Dunn, N.C.
- (18) See <http://www.census.gov/prod/2004pubs/04statab/health.pdf>, table no. 120. "Personal Healthcare Expenditures by Object and Source of Payment: 2002"
- (19) Ibid.
- (20) This policy was implemented during WWII in order to get around strict controls on money wages. Tax-free benefits were then used as a way of attracting better employees.
- (21) Op. cit. at note 2.
- (22) As quoted by Terree Wasley, "Certificate of Need: Poor Healthcare Policy," Mackinac Center for Public Policy, June 17, 1993.

## CON Regulated Services by State

(this information is summarized from the 2004 National Directory of Health Planning, Policy and Regulatory Agencies, the fifteenth edition published by the American Health Planning Association)

Categories	Acute Care	Air Ambulance	Amo Surg Ctr	Bum Care	Business Crmpts	Cardiac Cath	CT Scanners	Gamma knives	Home Hlth	ICF/MR	Ultrathrapy	Long Term Care	Med Off Bldg	Mobile H Tech	MR Scans	Neo-nl Int Care	Obstetric Svcs	Open Heart Svcs	Orth Trapept	PET Scans	Psychiatric Svcs	Rad Therapy	Rehab	Renal Dialys	Res Care FOC	Subacute	Substance Abuse	Swing Beds	Ultra sound	Other (Items not otherwise covered)		
Connecticut																																
Alaska																																Awaiting
Vermont																																
Maine																																
Georgia																																
West Virginia																																Behavioral
South Carolina																																
North Carolina																																IC & clinics
Mississippi																																Hosp & meth
Tennessee																																Mobile svcs
Dist. of Columbia																																
Kentucky																																
Rhode Island																																
New York																																
Hawaii																																
Maryland																																red. swing ber
Michigan																																Hosp & surg
Washington																																Hospice
New Hampshire																																
New Jersey																																
Illinois																																Other
Alabama																																EST & ALC
Missouri																																New Hosp
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Massachusetts																																
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Connecticut																															
Alaska																															Assisted living
Vermont																															
Maine																															
Georgia																															
West Virginia																															Benazoxanth
South Carolina																															
North Carolina																															IC & others
Mississippi																															Hospice, med
Tennessee																															Mobile svcs
Dist. of Columbia																															red, swing ber
Kentucky																															Hosp & Surg
Rhode Island																															Hospice
New York																															Other
Hawaii																															ESTD B.A.C.
Maryland																															New hosp
Michigan																															
Washington																															
New Hampshire																															
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Illinois																															
Alabama																															
Missouri																															
Iowa																															MS, SP, CT
Virginia																															Psych, crim
Oklahoma																															Hospice
Montana																															ICWA
Florida																															Assisted liv
Arkansas																															Other
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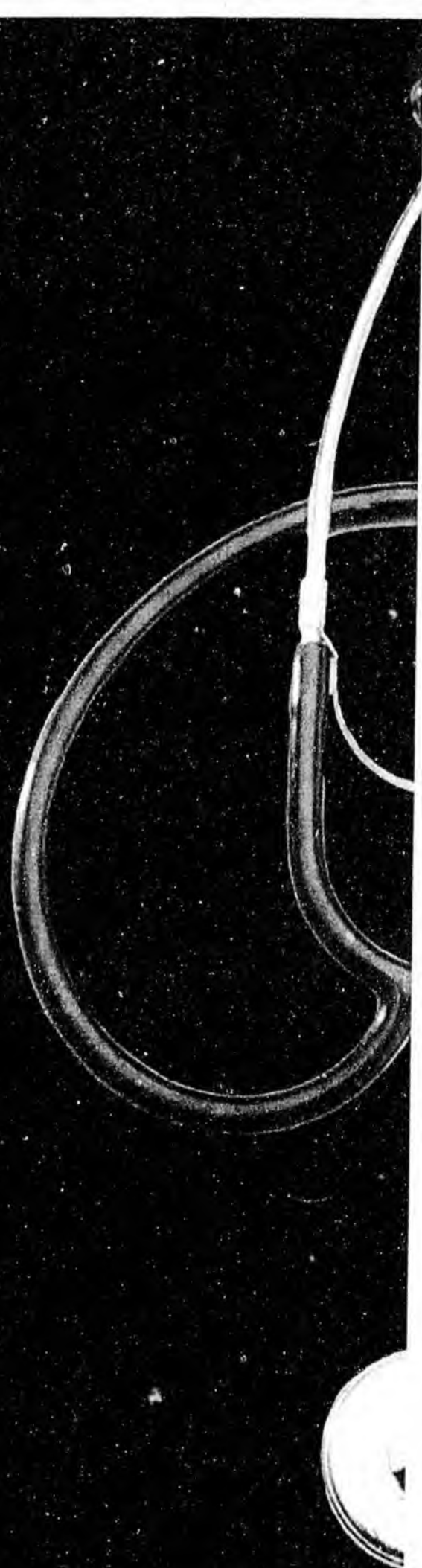
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