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- *"Testimony on H.B. 4: Medical Facility Certificate of Need"* Alaska House of Representatives Health Education and Social Services Committee, Juneau, AK (April 24, 2007).
- *"Testimony on H.B. 466"* Missouri House of Representatives Special Committee on Healthcare Facilities, Jefferson City, MO (February 6, 2007).
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- *"Testimony on Proposed Bill (H.B. 1537)"* Certificate of Need (CON) –Special Committee on Healthcare Facilities, Jefferson City, MO, (February 15, 2006).
- *"Testimony on Proposed Bill (H.B. 271)"* Hospital Ownership of Health Plans - House Health Care Policy Committee, Jefferson City, MO, (March 30, 2005).

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- *"Testimony on Proposed Bill (H.B. 585)"* Certificate of Need (CON) - House Health Care Policy Committee, Jefferson City, MO, (March 30, 2005).
- *"Testimony on Proposed Bill (H.B. 132)"* Certificate of Need (CON) - House Health Care Policy Committee, Jefferson City, MO, (March 12, 2003).
- *"Testimony on Proposed Bill (S.B. 449)"* Certificate of Need (CON) - Committee on Pensions and General Laws, Jefferson City, MO, (March 11, 2003).
- *"Missouri Health Facilities Review Committee (MHFRC) Proposed Rule Changes Testimony,"* Certificate of Need (CON) - Missouri Joint Committee on Administrative Rules (JCAR). Jefferson City, MO, (March 20, 2002).
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- *"Research for Valuations The Theory and Practice of Industry Data Gathering,"* Consultants' Training Institute Online Learning Lecture Series, National Association of Certified Valuation Analysts, (November 29, 2007).
- *"Valuation of Healthcare Ancillary Services Providers,"* Consultants' Training Institute, National Association of Certified Valuation Analysts, Philadelphia, PA (November 2, 2007).
- *"Valuation of Managed Care Organizations,"* Consultants' Training Institute Online Learning Lecture Series, National Association of Certified Valuation Analysts, (October 18, 2007).
- *"Valuation of Healthcare Ancillary Services Providers,"* Consultants' Training Institute, National Association of Certified Valuation Analysts, Phoenix, AZ (September 13, 2007).
- *"Aspects of Fraud Unique to Healthcare Valuation,"* Consultants' Training Institute's Online Learning Lecture Series, National Association of Certified Valuation Analysts, (August 9, 2007).
- *"Valuation of Ambulatory Surgery Centers,"* Eide Bailly, LLP Business Valuation Seminar. Minneapolis, MN (May 24, 2007.)
- *"Obtaining Certificates of Need For Outpatient Providers: Strategies for ASCs, Specialty Hospitals, Diagnostic Imaging, Cancer Treatment Centers, and Other Healthcare Facilities,"* Beard Audio Conferences, The Beard Group Law and Business Publishers (May 9, 2007).
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- *"IF WISHES WERE HORSES...' The Use of Empirical Data to Support Healthcare Valuations,"* The Institute of Business Appraisers 2006 Business Valuation Symposium, Clayton, MO (June 23, 2006).
- *"Valuation of Medical Practices in a Changing Regulatory and Reimbursement Environment,"* The Institute of Business Appraisers – Educational Course #1011. Clayton, MO (August 16, 2005).
- *"An Exciting Insight Into the Health Care Industry & Medical Practice Valuation,"* AICPA Course (#HCIV), sponsored by the Ohio Society of CPAs. Hudson, OH (September 13, 2002).
- *"Managed Care: Complete Guide to Mastering the Critical Health Care Issues,"* AICPA Course (#MCI), sponsored by the Indiana CPA Society. Indianapolis, IN (September 9, 2002).
- *"Health Care Consulting: New Practice Opportunities,"* AICPA Course (#HCC), sponsored by the Indiana CPA Society. Indianapolis, IN (October 8, 2001).
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- *"The Valuation of Healthcare Entities in a Changing Regulatory and Reimbursement Environment,"* The Institute of Business Appraisers—Educational Course #1011. Indianapolis, IN (July 17, 2000).
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- *"The Valuation of Healthcare Entities in a Changing Regulatory and Reimbursement Environment,"* Institute of Business Appraisers—Educational Course #1011. Cincinnati, OH (November 15, 1999).
- *"The Valuation of Healthcare Entities in a Changing Regulatory and Reimbursement Environment,"* Institute of Business Appraisers—Educational Course #1011. Kansas City, MO (October 18, 1999).
- *"Health Care Industry & Medical Practice Valuation,"* sponsored by Missouri Society of CPAs. St. Louis, MO (September 30, 1997).
- *"Health Care Industry & Medical Practice Valuation,"* sponsored by Georgia Society of CPAs. Atlanta, GA (September 29, 1997).
- *"Health Care Industry & Medical Practice Valuation,"* sponsored by Tennessee Society of CPAs. Brentwood, TN (September 15, 1997).
- *"Practice Abuse Seminar,"* Erie County Medical Society. Buffalo, NY (September 29, 1993)

ACADEMIC TEACHING ASSIGNMENTS

- *"Financial Benchmarking: Research and Application to the Healthcare Industry,"* Guest Instructor-Health Administration Program, Washington University School of Medicine, St. Louis, MO. Master of Health Administration (MHA) Program, Stuart Boxerman, D.Sc., Program Director. (January 27, 2005).
- *"The Surgical Hospital: Threat or Non-Threat to the Local Hospital,"* Guest Instructor-Health Administration Program, Washington University School of Medicine, St. Louis, MO, Master of Health Administration (MHA) Program, Stuart Boxerman, D.Sc., Program Director. (February 5, 2004).
- *"Practice Valuation: Issues for New Optometry Graduates,"* Practice Management IV Seminar, sponsored by University of Missouri—St. Louis. St. Louis, MO (October 21, 1998).
- *"Practice Valuation: Issues for New Optometry Graduates,"* Practice Management IV Seminar, Sponsored by University of Missouri - St. Louis, St. Louis, MO (October 23, 1997).
- *"Valuation of Health Care Professional Practices in a Changing Reimbursement & Regulatory Environment,"* Guest Instructor-Health Care Finance course (HA-667), Washington University School of Medicine St. Louis, MO, Master of Health Administration (MHA) Program, Robert S. Woodward, PhD, professor. (April 15, 1996).
- *"Valuation of Health Care Professional Practices in a Changing Reimbursement & Regulatory Environment,"* Guest Instructor-Health Care Finance course (HA-667), Washington University School of Medicine St. Louis, MO, Master of Health Administration (MHA) Program, Robert S. Woodward, PhD, professor. (April 5, 1995).
- *"Practice Abuse: Avoiding the Pitfalls of Private Practice,"* Medical Society of the County of Erie & Citibank, Buffalo, NY (September 29, 1993).
- *"Practice Management & Marketing Review,"* St. Vincent's Medical Center, Staten Island, NY (June 5, 1993).
- *"Negotiating Associateship Arrangements, & Practice Buy-ins,"* Winthrop University Hospital Mineola, NY (February 2, 1993).
- *"Practice Choice,"* Medical Society of the State of New York (MSSNY) State University of New York, Health Science Center at Syracuse, University Hospital. (March 11, 1992).
- *"Practice Management & Marketing Review,"* State University of New York Health Science Center at Syracuse University Hospital, Syracuse, NY (November 18, 1992).

LECTURES AND PRESENTATIONS

- "Developing and Implementing a Successful Certificate of Need Strategy, GE Healthcare Second Annual Outpatient Imaging Center Conference, Washington D.C., July 26, 2007.
- "Benefits of Physician Ownership of Ambulatory Surgery Centers," American Association of Ambulatory Surgery Centers Annual Meeting 2007, Denver Colorado, May 18, 2007.

LECTURES AND PRESENTATIONS (CONTINUED)

- "The Four Pillars" Supporting the Future of Healthcare: A Look at Market Forces," Missouri League for Nursing 2007 Annual Convention, Tan-Tar-A, MO, April 13, 2007.
- "Quantifying Business Interruption Damages," National Association of Certified Valuation Analysts Missouri State Chapter Meeting 2007, St. Louis, MO, January, 26, 2007.
- "*The Orthopedic Single Specialty Hospital: Is it Still Possible.*" Winning Off the Field: The AOSSM Practice Management Workshop, The American Orthopedic Society of Sports Medicine, Phoenix, AZ, December 1, 2006.
- "*The Attack on Orthopedic Providers at Federal and State Levels and How to Defend Yourself.*" Winning Off the Field: The AOSSM Practice Management Workshop, The American Orthopedic Society of Sports Medicine, Phoenix, AZ, December 1, 2006.
- "*Successful Advocacy,*" Panel Member, American Association of Ambulatory Surgery Centers State Leadership Retreat, Scottsdale, AZ, October 28, 2006.
- "*Aspects of Fraud in Healthcare Valuation*" The National Association of Certified Valuation Analysts, 13th Annual Consultants' Conference, San Francisco, CA (June 2, 2006).
- "*If Wishes Were Horses…The Use of Empirical Data to Support Healthcare Valuations*" New York State Society of CPAs, Business Valuation Conference, New York, NY (May 15, 2006).
- "*The Attack on Specialty and Niche Providers*" Beard Group & Renaissance Management, Inc, 2nd Annual Physicians Agreements and Joint Ventures Conference, Chicago, IL (November 3, 2005).
- "*Valuation Standards,*" St. Louis Business Valuation Roundtable, St. Louis, MO (November 2, 2005).
- "*Presenting the Truth: The Attack on Niche Providers*" American Surgical Hospital Association, 5th Annual Conference & Exhibits. San Francisco, CA (October 28, 2005).
- "*The Attack on Niche Providers*" [Panel Discussion] Texas Orthopaedic Association, 2005 Socioeconomic Summit. Austin, TX (October 7, 2005)
- "*Development of Professional Standards: Update on North American Business Valuation Standards Council*" [Panel Discussion] The Institute of Business Appraisers Midwest Regional Caucus 2005. Clayton, MO (August 16, 2005).
- "*Buy vs. Lease Decisions*" Building Owners and Managers Association International, The North American Commercial Real Estate Congress and The Office Building Show. Anaheim, CA (June 25, 2005).
- "*Benchmarking Using the Association's Statistics*" National Association of Healthcare Consultants, HealthCon 2005. Baltimore, MD (June 16, 2005).
- "*The Valuation of Ambulatory Surgery Centers and Outpatient Health Entities*" The National Association of Certified Valuation Analysts, 12th Annual Valuation Conference. Philadelphia, PA (June 2, 2005).
- "*Valuation of Medical Practices in a Changing Regulatory and Reimbursement Environment,*" Accountants Global Network, AGN North America Regional Meeting. St. Louis, MO (May 18, 2005).
- "*The Attack on Niche Providers*" The American Association of Ambulatory Surgery Centers, 27th Annual Meeting. Reno, NV (March 11, 2005).
- "*The Valuation of Ambulatory Surgery Centers*" The American Association of Ambulatory Surgery Centers, 27th Annual Meeting. Reno, NV (March 9, 2005).
- "*Making the Case For / Against Specialty Hospitals*" [Moderator] National Managed Health Care Congress, 17th Annual Conference. Washington D.C. (March 8, 2005).
- "*Valuation of Healthcare Enterprises in a Dynamic Market Economy*" Business Valuation Resources – Audio Conference. (December 2, 2004).
- "*Healthcare M&A Issues,*" International Business Brokers Association (IBBA) – Conference for Professional Development. Fort Worth, TX. (November 12, 2004).
- "*The Specialty Hospital Moratorium: The Impact on Physician Ownership of Specialty Surgical Hospitals*" Healthcare Financial Management Association (HFMA)-Fall Conference. Kansas City MO (September 16, 2004).
- "*The Valuation of Healthcare Entities in a Changing Reimbursement and Regulatory Environment,*" American Academy of Matrimonial Lawyers, Ohio Chapter – 2004 Lake Las Vegas Conference. Lake Las Vegas, NV (June 25, 2004).

LECTURES AND PRESENTATIONS (CONTINUED)

- *"The Don'ts and Don'ts of Healthcare Valuation: The Valuation of Healthcare Entities in a Changing Reimbursement and Regulatory Environment,"* Institute of Business Appraisers (IBA) – 2004 Annual Business Valuation Conference. Las Vegas, NV (June 9, 2004).
- *"The Surgical Hospital: Threat or Non-Threat to the Local Hospital,"* Academy Health -- 2004 Annual Research Meeting. San Diego, CA (June 6, 2004) [Poster].
- *"The Surgical Hospital: Threat or Non-Threat to the Local Hospital,"* American Surgical Hospital Association – Third Annual Conference and Exhibits. San Diego, CA (November 22, 2003).
- *"The Valuation of Healthcare Entities in a Changing Regulatory and Reimbursement Environment: A Critical Update"* Accountants Global Network – North American BV Share group Web conference (November 13, 2003).
- *"Whistling Past the Graveyard: The Value of Professional Appraisal Designations in a Changing Regulatory and Competitive Environment"* American Society of Appraisers – St. Louis Chapter Membership Meeting. St. Louis, MO (April 24, 2003).
- *'From Spreadsheet to Wall Street: A Panel Discussion on the Theory and Reality of Building Value in Homecare"* American Association for Homecare – Leadership Conference. St. Petersburg, FL (February 26, 2003).
- *"But for the Purported Wrongful Act: the Analysis & Valuation of Healthcare Commercial Damages in a Changing Reimbursement & Regulatory Environment"* Eastern Economic Association (session sponsored by the National Association of Forensic Economists) – Eastern Economic Association Annual Conference 2003. New York, NY (February 22, 2003).
- *"Healthcare Mergers & Acquisitions: Recent Developments & Issues"* International Business Brokers Association, Inc. – 36th Conference & Educational Program. Los Angeles, CA (November 16, 2002).
- *"The Effect of the Changing U.S. Economy on Healthcare Vauation"* Missouri Society of Certified Public Accountants—2002 Healthcare Forum. St. Louis, MO (November 13, 2002).
- *"Duped by Cries of Duplication – The Failure of Certificate of Need (CON) Laws"* Missouri Society of Certified Public Accountants – 2002 Healthcare Forum. St. Louis, MO (November 13, 2002).
- *"The Effect of the Changing U.S. Economy on Healthcare Valuation"* American Society of Appraisers/Canadian Institute of Chartered Business Valuator – 5th Joint Advanced Business Valuation Conference. Orlando, FL (October 25, 2002).
- *"Duped By Cries Of Duplication: The Failure of Certificate of Need Regulation"* Academy for Health Services Research and Health Policy – 2002 Annual Research Meeting. Washington, DC (June 23, 2002) [Poster].
- *"The Effect of the Changing U.S. Economy on Healthcare Valuation: An Examination of the Impact of Recent Events"* National Association of Certified Valuation Analysts – 9th Annual Business Valuation Conference. San Diego, CA (May 23, 2002).
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- *"Valuation of Healthcare Intangible Assets,"* Missouri Society of CPAs (MSCPA) – 2001 Healthcare Conference. Columbia, MO (November 13, 2001).
- *"Valuation of Healthcare Intangible Assets: The Definition, Classification, and Determination of Intangible Assets in Healthcare Service Sector Entities,"* Internal Revenue Service – Large and Midsize Business & Engineering, Continuing Professional Education, St. Louis, MO (August 8, 2001).
- *"Valuation of Healthcare Intangible Assets: The Definition, Classification, and Determination of Intangible Assets in Healthcare Service Sector Entities,"* New York State Society of CPAs – Business Valuation Conference, New York, NY (June 18, 2001).
- *"Valuation of Healthcare Assets: the Definition, Classification, and Determination of Intangible Assets in Healthcare Service Sector Entities,"* Institute of Business Appraisers – 2001 National Conference. Orlando, FL (May 10, 2001).
- *"Lessons from Market Competition in Healthcare,"* Institute of Certified Business Counselors – 2000 Annual Meeting. Tempe, AZ (September 22, 2000).

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- *"Lessons from Market Competition in Healthcare: Love Everyone, Trust No One & Paddle Your Own Canoe,"* American College of Healthcare Executives – 2000 Congress on Healthcare Management. Chicago, IL (March 29, 2000).
- *"Developments in the Valuation of Healthcare Service Businesses,"* Business Valuation Association of Chicago. Chicago, IL (March 23, 2000).
- *"The Valuation of Healthcare Entities in a Changing Regulatory and Reimbursement Environment,"* American Society of Appraisers – 18th Annual Advanced Business Valuation Conference. New Orleans, LA (October 29, 1999).
- *"Love Everyone, Trust No One, & Paddle Your Own Canoe,"* Institute of Certified Business Counselors – Annual Meeting. Portland, OR (October 1, 1999).
- *"Healthcare Business and Industry Research and Its Application: The Internet and Other Sources,"* CPA Associates International—Medical Professionals Seminar. Denver, CO (August 17, 1999).
- *"Going Ambulatory: Development of a Plan,"* Ambulatory Surgery Centers – Keys to Business Success, FMR Communications, Ross & Hardies. Chicago, IL (October 13, 1998).
- *"PPMC Acquisitions of Physician Practices: Valuation and Consulting Issues,"* Institute of Certified Business Counselors Annual Meeting. Tempe, AZ (September 18, 1998).
- *"PPMC Acquisitions of Physician Practices: Valuation and Consulting Issues,"* CPA Associates International, Medical Professionals Seminar. Atlanta, GA (August 17, 1998).
- *"The Valuation of Healthcare Entities,"* St. Louis Business Valuation Round Table, St. Louis, MO (1998).
- *"Focus Group I: Valuation of Medical Practices,"* Institute of Business Appraisers 1998 National Conference: The Future of Business Valuation. San Antonio, TX (1998).
- *"Developing Successful Management Services Organizations,"* Hospital and Health Systems: Strategic Options and Practical Guidance, sponsored by FMR Communications. Chicago, IL (November 4, 1997).
- *"Anatomy of an MSO Gone Wrong—Stabilizing and Restructuring MSOs,"* Advanced Financial and Operational Strategies for Management Services Organizations & Physician Practice Management Companies, sponsored by IBC USA Conferences. Chicago, IL (October 31, 1997).
- *"Historical Review,"* 2nd Annual PRN Leadership Retreat—Physician Resource Network. Elkhart Lake, WI (February 14-15, 1998).
- *"Implementation Phase – Report on Group Services, Human Resources—Central Business Office,"* 2nd Annual PRN Leadership Retreat—Physician Resource Network. Elkhart Lake, WI (February 14-15, 1998).
- *"Managed Care Contracting,"* 2nd Annual PRN Leadership Retreat—Physician Resource Network. Elkhart Lake, WI (February 14-15, 1998).
- *"Financial Report and Budget / Proforma,"* 2nd Annual PRN Leadership Retreat—Physician Resource Network. Elkhart Lake, WI (February 14-15, 1998).
- *"Introduction to Strategic Plan, Part I,"* and *"Strategic Plan, Part II,"* 2nd Annual PRN Leadership Retreat—Physician Resource Network. Elkhart Lake, WI (February 14-15, 1998).
- *"Valuations of Medical Practices,"* 1997 Medical Professional Seminar, sponsored by CPA Associates International, Inc. Baltimore, MD (August 18-19, 1997).
- *"Valuation of Physician Practices: A Workshop for Physicians and Practice Management Companies,"* Practice Management Financing Partnership, sponsored by Global Business Research, Ltd. Philadelphia, PA (July 23, 1997).
- *"Anatomy of an MSO Gone Wrong,"* American College of Healthcare Executives Congress on Healthcare Management. Chicago, IL (March 4, 1997).
- *"Valuing a Medical Practice from a Physician's Perspective,"* National Litigation Support Services Association Educational and Networking Conference. Tempe, AZ (January 23, 1997).
- *"How to be an Effective Board Member Chairperson,"* PRN Board of Managers Chairperson Retreat. Kohler, WI (January 18-19, 1997).
- *"Research/Data Sources & Capital Requirements for Radiology Network Development,"* The Radiology Business Management Association Midwest Conference. Minneapolis, MN (October 20-22, 1996).
- *"Valuation of Health Care Entities - An Update,"* paper presented at the Pittsburgh Chapter of the American Society of Appraisers, Business Valuation Seminar. Pittsburgh, PA.

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- "*Valuation of Health Care Entities, in a Changing Regulatory and Reimbursement Environment,*" Clifton Gunderson LLC, Valuation and Litigation Services Conference. Itasca, IL.
- Acquisitions by Practice Management Companies (PMCs) and Hospital Companies in the Public Market," American Institute of Certified Public Accountants. New Orleans, LA (December 4-5, 1996).
- "*Medical Practice Valuation, Operation and Sales,*" IBC 21st Annual Meeting and Seminar (September 20, 1996).
- "*Did Marcus Welby Worry About Profitability?*" LAWCO Healthcare Conference '96. Rochester, MN (June 10-11, 1996).
- "*Hospital –Physician Affiliation//Integration//Acquisition: Developing a Plan and Agenda,*" LAWCO Healthcare Conference '96. Rochester, MN (June 10-11, 1996).
- "The Anatomy of a Practice: Conducting a Management Assessment and Operational Review," LAWCO Healthcare Conference '96. Rochester, MN (June 10-11, 1996).
- "*Valuation of Health Care Entities in a Changing Regulatory and Reimbursement Environment,*" North Carolina Association of Certified Public Accountants 1996 Health Care Industry Conference. Greensboro, NC (July 27-28, 1996).
- "*Practice Valuation Issues: What Healthcare Executives Must Know,*" American College of Healthcare Executives. Chicago, IL (March 10-14, 1996).
- "*Valuation of Physician Practices in a Changing Reimbursement and Regulatory Environment,*" Global Business Research. Miami, FL (January 24-26, 1996).
- "*Valuation of a Medical Practice,*" National CPA Healthcare, Advisors Association. Las Vegas, NV (January 11-12, 1996).
- "*Introduction and Brief Overview of Current Developments in the Health Care Fields*" Developing a Hospital/Physician Integration/Affiliation Practice Acquisition Program. Health Capital Consultants (HCC). Marriott New York Marquis, New York, NY (January 9, 1996).
- "*Identifying and Evaluating Potential Acquisitions and Affiliation Targets,*" Developing a Hospital/Physician Integration/Affiliation Practice Acquisition Program. Health Capital Consultants (HCC). Marriott New York Marquis. New York, NY (January 9, 1996).
- "*Marketing/Packaging Acquisitions and Affiliation Opportunities to Prospects*" Developing a Hospital/Physician Integration/Affiliation Practice Acquisition Program. Health Capital Consultants (HCC). Marriott New York Marquis, New York, NY (January 9, 1996).
- "*Compensation Plans,*" Developing a Hospital/Physician Integration/Affiliation Practice Acquisition Program. Health Capital Consultants (HCC). Marriott New York Marquis, New York, NY (January 9, 1996).
- "*Misuse of Business Valuation Methodology Critical Solutions—Litigation Issues,*" 1996 Conference. Northbrook, IL (January 15, 1996).
- "*Yes, We Have No Bananas: The Shocking Truth About the Market Approach,*" Practice Valuation Study Group (PVSG). Charleston, SC (November 4, 1995).
- "*Issues in Valuing Health Care Professional Practices,*" Ohio Chapter of the American Academy of Matrimonial Lawyers. Columbus, OH (October 9, 1995).
- "*Issues in Valuing Health Care Professional Practices in a Changing Reimbursement & Regulatory Environment,*" Business Valuation Association. Chicago, IL (September 28, 1995).
- "*Valuation of Physician Practices in a Changing Reimbursement & Regulatory Environment,*" Acquiring and Integrating Physician Practices, sponsored by Global Business Research. Chicago, IL (September 13-14, 1995).
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ASHNHA Comments on CS for House Bill 337 (HES Version 'N')
Prepared by: Rod Betit, President/CEO • April 4, 2008

I. Sectional Overview:	Recommendation
• Section 1 - Legislative Findings & Intent	SUPPORT
• Section 2 - Statewide Health Plan	SUPPORT
• Section 3- Re-define "expenditure"	OPPOSE
• Section 4 - Define "health care facility" & Repeal CON	OPPOSE
• Section 5 - Add new definitions	AMEND
• Section 6 - Health Care Information Office & Reporting	AMEND
• Section 7 - Establish Commission	AMEND
• Section 8 - CON Repeal Transition Steps	OPPOSE
• Section 10 - CON Study	SUPPORT
• Section 11 - Effective Date for Section 9	OPPOSE
• Section 12 - Mandatory Reporting Effective Date	SUPPORT

II. Sectional Analysis:

Section 1 - Findings & Intent: SUPPORT

ASHNHA members agree with the policy statement expressed in this Section.

Section 2 - Statewide Health Plan SUPPORT

ASHNHA members support the creation and regular updating of a statewide health plan.

Section 3 - Re-define Expenditure OPPOSE

This is a new section modifying the definition currently being used to determine which projects exceed the dollar threshold that would trigger a CON review. This new language is unclear to ASHNHA members as to how it would improve or clarify projects under review by the department. In addition this new language only includes equipment when computing project costs. Current law includes both equipment and property related costs. Current language is recommended over this new proposed language.

Section 4 - Define "Health Care Facility" & Partial Repeal of CON: OPPOSE

This Section would repeal CON in municipalities or boroughs with populations over 60,000 persons not including recipients of public health care who are military or Indian Health Service covered. The effect of this language would be to effectively repeal CON in Mat-Su, Anchorage and Fairbanks. Repeal of CON would be detrimental to Alaska consumers, not helpful.

HB337 is being pitched as a way to increase competition and decrease costs, but it would have the exact opposite effect. As stated recently in a St Louis editorial, the fact that repeal of CON does not increase competition and lower costs is often *"counter-intuitive."*

The editorial goes on to note that *"Wisconsin and Ohio both did away with their CON requirements. But the promised savings failed to materialize. What came instead was.*

- *26 new hospitals were built when Ohio's CON law was repealed.*
- *82 new multi-million dollar MRI and CT scan centers were opened.*

- *The number of open heart surgeries performed in the state jumped by 38 percent. Many were judgment calls, done at the discretion of doctors who otherwise would opt for a more conservative approach than surgery.*
- *When Pennsylvania's CON law was repealed, the number of MRI machines jumped from 78 to 187 and capacity at cardiac catheterization labs jumped by 90 percent.*

"All that new equipment and expertise has to be paid for somehow. A 2001 study by Chrysler, Ford and General Motors shows the effect. The study examined health costs over several years in eight states, including Missouri. It found that costs were 11 to 39 percent lower in states with CON requirements than in those without it.

"In a landmark study, Dartmouth University researchers found that Medicare pays twice as much per patient in Miami as it does in Minneapolis. The difference largely is because Florida patients are more likely to be referred to medical specialists, where they often are given expensive tests and admitted to hospitals.

"But the patients in Miami don't live longer or have a better quality of life than those in Minneapolis. A more recent Dartmouth study found that patients in cities where health spending was highest actually died sooner than those where it was lower."

Alaska would be taking a huge risk by enacting any repeal of CON absent empirical data that increased competition and lower costs would actually come about. That data does not exist at the present time. The most likely impact of repealing CON would be to further erode community hospitals financial ability to provide needed medical services to everyone, including those who cannot pay.

The amount of Bad Debt that hit Alaska's hospitals increased by 55% between 2006 and 2007. Nationally during this same period Bad Debt increased 14.1%. Repeal of CON would reduce hospitals revenue from more profitable service areas that are used to offset part of this growing Bad Debt problem, and to fund the 24/7 areas of medical care like Emergency Departments.

<u>Section 5 - Add New Definitions:</u> AMEND

Some of the proposed definitions are helpful (#11, 12, 14, 15, & 16) while two are not, #13 dealing with IDTFs versus a practice with imaging equipment and #17 which attempts to define a 'physician office'.

Definition #13 should be replaced with language from HB 345 that clarifies when imaging equipment purchased for a physician's office is exempt from CON review. Adding this language in place of definition #13 would also eliminate 80% of the lawsuits and appeals currently before the State on imaging CON decisions that the Department of Health & Social Services has made in the last two years.

Definition #17 should be deleted in its entirety as there is no useful purpose for attempting to define what is or is not a physician office. Physician offices have always been exempt from CON in Alaska and this proposed definition would simply create interpretive complexity to an area that is already very clear.

<u>Section 6 - Health Care Information Office & Mandatory Reporting</u> AMEND

ASHNHA members strongly support efforts to provide consumers with better information to guide their health care purchases but there are several amendments which are important to make to this Section. Specifically:

- Replace language on lines 12 & 13, page 5 with new language that reads "(1) information about health care services, price, and quality to aid consumers in making health care decisions; and"
- Add language on line 22, page 5, after the word 'information' "with the health care facility".
- Add after 'and' on line 1, page 7, a new #11 that reads "(11) a list of physicians who accept patients with Medicare coverage;" Renumber accordingly.
- Replace language on lines 12 - 14, page 7 with new language that reads "(1) information on costs to and bills payable by the consumer for health care services that include both facility and physician components of care.
- Add new E and F after line 27, page 8 that add requirement for pharmacies and physicians to report. It is critical that pharmacy and physician information be part of the data base that consumers have access to in making health care decisions. New language to add:
  - "(E) a licensed pharmacy; and
  - "(F) a physician's office.

<u>Section 7 - Establish Health Care Commission:</u> AMEND

ASHNHA strongly supports creation of a Health Care Commission. While there are several different membership structures being proposed in different legislation, it is important that a Commission of some structure is created.

It is important to note also that in this HES version of HB 337, the responsibilities of the Commission have been diluted to simply review and advise the Department on health care information reporting rather than "approving" the process (see line 9 on page 11). ASHNHA strongly recommends amending this section to give the Commission authority to define the reporting requirements for each health care category. The Commission is the more appropriate body for determining what is most useful to consumers in weighing health care decisions that must be made.

<u>Section 8 - CON Repeal Transition Steps:</u> OPPOSE

ASHNHA's members do not support any repeal of CON and therefore believe this section should be deleted.

Section 9 - CON Transition Regulations: OPPOSE

ASHNHA's members do not support any repeal of CON and therefore believe this section should be deleted.

Section 10 - CON Study: SUPPORT

ASHNHA strongly supports completion of an Alaska specific CON Study to address the question of what impact CON repeal would have in Alaska. Future debate of this topic would be enhanced by identification of any data unique to Alaska that might shed light on any positive or negative impacts that the Alaska CON process has had on consumer access and cost for health care services.

Section 11 - Effective Date for Section 9: OPPOSE

ASHNHA's members do not support any repeal of CON and therefore believe this section should be deleted.

Section 12 - Mandatory Reporting Date: AMEND

This HES version of HB 337 continues to have a July 1, 2008 effective date for reporting information. Even with a staggered implementation of this provision for different health care provider types, it is unrealistic to expect that the Department can actually begin receiving and posting reported information prior to July 1, 2009.

Thank you for the opportunity to testify and express ASHNHA's members' opinions about this legislation.

U.S. Department of Justice

Antitrust Division

Competition in Healthcare and Certificates of Need

JOSEPH M. MILLER
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U.S. Department of Justice, Antitrust Division

January 31, 2008[1]

Good afternoon. I appreciate the invitation to the Antitrust Division of the U.S. Department of Justice to share our views on the impact of Certificate of Need ("CON") laws on healthcare markets.

My name is Joseph Miller. I am the Assistant Chief of the Litigation I Section of the Antitrust Division. The Litigation I Section enforces the antitrust laws in a wide variety of industries, including healthcare markets. Our attorneys confer closely with a large team of economists holding doctorates in the study of markets and their performance, including a number with specialization in the performance of healthcare markets. We also confer closely with the attorneys and economists at the Federal Trade Commission, who have dedicated time to the study of healthcare markets.

The Antitrust Division and the FTC have investigated and litigated antitrust cases in markets across the country involving hospitals, physicians, ambulatory surgery centers, stand-alone radiology programs, medical equipment, pharmaceuticals and other healthcare products. Through that work we have developed a substantial understanding of the competitive forces that drive innovation in and contain the costs of healthcare. We regularly issue informal advisory letters on the application of the antitrust laws to healthcare markets, and periodically issue reports and general guidance to the healthcare community. For example, in 2003, we conducted 27 days of hearings on competition and policy concerns in the healthcare industry, heard from approximately 250 panelists, elicited 62 written submissions, and generated almost 6,000 pages of transcripts.[2] As a result of that effort, we published an extensive report, entitled *Improving Health Care: A Dose of Competition*, in July 2004.

I. Scope of Remarks

The Antitrust Division's experience and expertise has taught us that Certificate of Need laws pose a substantial threat to the efficient performance of healthcare markets. By their very nature, CON laws create barriers to entry and expansion and thus restrict free and open

[1] This paper draws significantly from testimony delivered on behalf of the Antitrust Division to the General Assembly and Senate of the State of Georgia on February 23, 2007.

[2] This extensive hearing record is largely available at http://www.ftc.gov/bc/healthcare/research/healthcarehearing.htm.

competition. They undercut consumer choice, weaken markets' ability to contain healthcare costs, and stifle innovation.

We have examined historical and current arguments for CON laws, and conclude that such arguments provide no economic justification for depriving consumers' of the benefits of free markets. To the extent that CONs are used to further non-economic goals, they impose substantial costs. Such goals, purportedly furthered through CON laws, can be more efficiently achieved through other mechanisms. We hope you will carefully consider the substantial costs that CON laws impose on consumers as you evaluate whether to eliminate those laws in Alaska.

I do not testify today to discuss the details of the legislation you are considering. I am, however, generally familiar with the issues before you and recognize them as issues that CON laws present in other states and other markets. My remarks, accordingly, will focus on the impact of and justifications for CON laws generally.

It is not the Antitrust Division's intent to "favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, [our] goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices . . ."[3] Our overall mission is to preserve and promote economic competition rather than to preserve any particular marketplace rival or group of rivals.

II. Importance of Competition and the Harm Caused by Regulatory Barriers to Entry

A. The Benefits of Competition in Healthcare

Our concerns about the harm from CON laws are informed by one fundamental principle: market forces improve the quality and lower the costs of healthcare services. They drive innovation and ultimately lead to the delivery of better healthcare. Government intervention can undermine market forces to the detriment of healthcare consumers.

In our antitrust investigations we often hear the argument that healthcare is "different" and therefore competition principles do not apply to the provision of healthcare services. The proposition that competition cannot work in healthcare is simply not true. Engineers and lawyers have made similar arguments that competition does not work in their industries and, in fact undermined other social goods advanced by their professions. Such arguments have been rejected by the courts, and private restraints on competition have long been condemned.[4] Indeed, at least since the Supreme Court's seminal 1943 decision in a case brought by the Department of Justice against the American Medical Association, competition has played a critical role in

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[3] Statements of Antitrust Enforcement Policy in Health Care, August 1996, Introduction, pg. 3 (available at: http://www.usdoj.gov/atr/public/guidelines/1791.htm).

[4] *F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990); *National Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978).

shaping the delivery of healthcare in this country.[5] The Antitrust Division and the Federal Trade Commission have worked diligently to make sure that private barriers to that competition do not arise.

During our extensive healthcare hearings in 2003, we obtained substantial evidence generally about the role of competition in our healthcare delivery system and reached the conclusion that vigorous competition among healthcare providers "promotes the delivery of high-quality, cost-effective healthcare." Specifically, competition results in lower prices and broader access to health care and health insurance, while non-price competition can promote higher quality.[6]

This finding is not new. We saw in the 1990s the growth of managed care and the impact it had on the cost and availability of insurance. Competition among and between hospitals and physicians intensified with the development of managed care organizations. In addition to putting pressure on costs, managed care plans have pressured providers to use shorter hospital stays and to offer alternative outpatient treatments. This evolution in health care purchasing led to lower costs and increased choice without sacrificing quality. Moreover, lower costs and improved efficiency made health insurance more affordable and available.

Competition also helped bring to consumers important innovations in healthcare technology. For example, health plan demand for lower costs and "patient demand for a non-institutional, friendly, convenient setting for their surgical care" drove the growth of Ambulatory Surgery Centers (ASCs).[7] Ambulatory surgery centers offered patients more "convenient locations, shorter wait time, and lower coinsurance than a hospital department."[8] Important to the success of these competitive forces in improving the delivery of care to consumers was the availability of technological advances, such as endoscopic surgery and advanced anesthetic agents.[9] Thus, competition harnessed this new technology and brought it to consumers in the lower cost, more convenient setting of ambulatory surgery centers. The impact on traditional general acute care hospitals led to those hospitals responding to the competition by delivering more care, in a better manner, in an outpatient setting, both at their own campuses and at ambulatory surgery centers in which they invested.

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[5] *American Medical Association v. U.S.*, 317 U.S. 519, 529 (1943).

[6] *Improving Health Care: A Dose of Competition*, ch. 3 § VIII and Executive Summary at 4 (July 2004) available at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf. ("*A Dose of Competition*").

[7] Id., Ch. 3 at 25.

[8] Medicare Payment Advisory Commitions (MedPAC), Report to the Congress: Medicare Payment Policy § 2F, at 140 (2003), available at http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf.

[9] A Dose of Competition, at ch. 3 at 24.

This type of competitive success story has occurred again and again in healthcare in the area of pharmaceuticals, urgent care centers, and elective surgeries such as Lasik procedures, to name just a few. Without private or governmental impediments to their performance, we can expect healthcare markets to continue to deliver these benefits.

B. CON Laws Create Barriers to Beneficial Competition

CON laws are a classic government-erected barrier to entry, and by their nature are an impediment to the proper functioning of the market process. Accordingly, in *A Dose of Competition*, the Federal Trade Commission and we urged the states to rethink their CON laws.[10]

1. Original Cost-Control Reasons For CON Laws No Longer Apply

We made that recommendation in part because the original reason for the adoption of CON laws is no longer valid. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974, which offered incentives for states to implement CON programs. At the time, the federal government and private insurance reimbursed healthcare charges predominantly on a 'cost-plus" basis, which provided incentives for over-investment. The hope was that CON laws would provide a counterweight against that skewed incentive.

In considering this historical justification for CON laws, we need to keep clear that a number of other arguments made today in support of CON laws were not part of the rationale for their original adoption –

* CON laws were not adopted as a means of cross-subsidizing care;
* CON laws were not adopted in order to have centralized planning of the location and nature of healthcare facilities; and,
* CON laws were not adopted to protect the health and safety of the population from poor quality medicine.

Instead, CON laws were adopted because excessive capital investments, spurred by the then-current cost-plus method of reimbursement, were driving up healthcare costs. There was concern that, because patients are usually not price-sensitive, providers engaged in a "medical arms race" by unnecessarily expanding their services to offer the perceived highest quality services.[11]

CON laws appear to have failed in their intended purpose of containing costs. Several studies have examined the effectiveness of CONs in controlling costs. The empirical evidence

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[10] *A Dose of Competition*, Executive Summary at 22.

[11] *A Dose of Competition*, Ch. 8, pg. 1-2.

on the economic effects of CON programs has demonstrated near-universal agreement among health economists that CON laws were unsuccessful in containing healthcare costs.[12]

In addition to the fact that CON laws have been ineffective in serving their original purpose, CON laws should be reexamined because the reimbursement methodologies that may in theory have justified them initially have changed significantly since the 1970s. The federal government no longer reimburses on a cost-plus basis. In 1986, Congress repealed the National Health Planning and Resources Development Act of 1974. Additionally, health plans and other purchasers routinely bargain with healthcare providers over prices. Essentially, government regulations have changed in a way that eliminates the original justification for CON programs.[13]

2. Protecting Revenues of Incumbents Does Not Justify CON Laws

Incumbent hospitals often argue that they should be protected against additional competition so that they can continue to cross-subsidize care provided to uninsured or under-insured patients. Under this rationale, CON laws would impede the entry of such healthcare providers as independent ambulatory surgery centers, free-standing radiology or radiation-therapy providers, single- or multi-specialty physician-owned hospitals, because if these new competitors were to enter the marketplace, community hospitals could not continue to exploit their existing market power over consumers. Put another way, without CON laws, we would see new, higher-quality, low cost providers in the marketplace, which would put competitive pressure on incumbent providers, and deprive them of revenues they could put to a charitable use.[14]

We fully appreciate the laudatory goal of providing sufficient funding for community hospitals so that these hospitals can provide health care services to those who cannot afford them and for whom government payments are either unavailable or too little to cover the cost of care. But, we also want to make clear that the use of government barriers to entry to fund indigent care has costs. There are more efficient ways to accomplish this goal without incurring the costs of impeding the proper functioning of health care markets. Essentially, by protecting incumbent hospitals from competition, CON laws allow dominant hospitals to tax consumers through the exercise of market power in order to pursue the charitable goal of providing care to other, less fortunate consumers. In using this funding mechanism, however, the CON laws may do more harm than good.

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[12] David S. Salkever, Regulation of Prices and Investment in Hospital in the United States, in 1B Handbook of Health Economics, 1489-90 (A.J. Culyer & J.P. Newhouse eds., 2000) ("there is little evidence that [1970's era] investment controls reduced the rate of cost growth.")

[13] *A Dose of Competition* at pg. 1-6.

[14] Note the irony of this argument. What started as laws intended to control costs have become laws intended to inflate costs. Proponents of CON laws now would use these barriers to entry to stifle competition, protect incumbent market power, frustrate consumer choice, and keep prices and profits high.

First, CON laws harm the consumers who would have chosen alternative, lower priced, higher quality, or more convenient sources of care.

Second, CON laws impose that cost without any clear evidence that other desired social goals are advanced. The evidence to date indicates that new competition does not undercut community hospitals' ability to fulfill charitable missions. Recently the federal government studied just this issue in connection with the emergence of single-specialty hospitals around the country. The study found that, for several reasons, specialty hospitals did not undercut the financial viability of rival community hospitals.[15] One substantial reason for this was that specialty hospitals generally locate in areas that have above average population growth. Thus, they are competing for a new and growing patient population, not just siphoning off the existing customer base of the community hospitals.

Third, new competition can force community hospitals to improve their performance. In studying the effect of single-specialty hospitals, MedPAC found that the community hospitals responded to the competition by improving efficiency, adjusting their pricing, and expanding profitable lines of business.[16] Community hospitals encouraged physicians to perform procedures on the hospital campus by developing centers of excellence and building physician offices on campus.[17] Overall, community hospitals affected by specialty hospital entry maintained profit margins in line with national averages. Rather than undercutting community hospitals, new entry drives them to do a better job. Thus, in addition to the harm to the consumers who would have chosen the new healthcare provider, CON laws harm society in general by depriving it of the increased efficiency that competition would have brought to the health care market.

3. CON Laws Impose Other Costs And May Facilitate Anti-Competitive Behavior

CON laws appear to raise a particularly substantial barrier to entry and expansion of competitors because they create an opportunity for existing competitors to exploit procedural

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[15] Report to the Congress: Physician-Owned Specialty Hospitals Revisited, pg. 21-25 (August 2006), available at http://www.medpac.gov/publications/congressional_reports/Aug06_specialtyhospital_mandated_report.pdf. ("MedPAC 2006 Report") (concluding that physician-owned specialty hospitals admit a lower proportion of Medicaid patients)

[16] Other studies have found that the presence of for-profit competitors leads to increased efficiency at nonprofit hospitals. Kessler, D. and McClellan M., "The Effects of Hospital Ownership on Medical Productivity," RAND Journal of Economics 33 (3), 488-506 (2002).

[17] Greenwald, L. et al., "Specialty Versus Community Hospitals: Referrals, Quality, and Community Benefits," *Health Affairs* 25, no. 1 (2006): 116-117. *See also* Stensland J. and Winter A., "Do Physician-Owned Cardiac Hospitals Increase Utilization?" *Health Affairs* 25, no. 1 (2006): 128 (some community hospitals have responded to the presence of specialty hospitals by recruiting physicians and adding new cardiac catheterization labs).

opportunities to thwart or delay new competition. Such behavior, commonly called "rent seeking" conduct, is a well-recognized consequence of regulatory intervention in the market.[18] Essentially, an existing competitor uses the hearing and appeals process to cause substantial delays, leading both the existing competitor and the new entrant to divert significant funds away from delivering healthcare and to spend them on legal fees, consulting fees, and lobbying efforts. Moreover, much of this conduct, even if exclusionary and anticompetitive, is unlikely to be subject to legal challenge as a violation of the antitrust laws because it involves petitioning of the state government by the existing competitor.[19] Indeed, during our hearings, we received evidence of the widespread recognition that existing competitors use the CON process "to forestall competitors from entering an incumbent's market."[20]

We have found that existing competitors, at times with the encouragement or acquiescence of state officials, go further and enter into agreements not required by the CON laws but nonetheless facilitated by them. Two examples arise from West Virginia, and a third comes from Vermont.

In the first West Virginia case, we found that a Charleston, West Virginia hospital used the threat of objection during the CON process, and the potential ensuing delay and cost, to induce a hospital seeking a certificate of need for an open heart surgery program not to apply for it at the location that would have well served Charleston consumers and provided greater competition for their business.[21] Instead, the Charleston hospital successfully prevented the possibility of this competing open heart program. The state authorities never had the opportunity to decide whether under the CON laws that second program would have been approved because of the unlawful agreement among the hospitals.

In the second West Virginia case, two closely competing hospitals decided to allocate healthcare services between themselves.[22] The informal urging of state CON officials led them to agree unlawfully that only the one hospital would apply for an open heart program and only the other would apply to provide cancer services. Again, the state took no official action and consumers were deprived of the potential competition between these hospitals.

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[18] Joskow, Paul and Rose, Nancy, "The Effects of Economic Regulation." *Handbook of Industrial Organization, vol. 2*, Schmalensee and Willig, ed. Amsterdam: North-Holland, 1989.

[19] *Eastern Rail. Pres. Conf. v. Noerr Motor Frgt., Inc.*, 365 U.S. 127 (1961).

[20] *A Dose of Competition*, Executive Summary at 22.

[21] *U.S. v. Charleston Area Medical Center, Inc.*, Civil Action 2:06-0091 (S.D.W.Va. 2006) (available at: http://www.usdoj.gov/atr/cases/f214400/214477.htm).

[22] *U.S. v. Bluefield Regional Medical Center, Inc.*, 2005-2 Trade Cases ¶ 74,916 (S.D. W.Va. 2005).

A third example comes from the State of Vermont. There, home health agencies entered into territorial market allocations, again under cover of the state regulatory program, to give each other exclusive geographic markets.[23] That state's CON laws prevented competitive entry, which normally might have disciplined such cartel behavior. We found that Vermont consumers were paying higher prices than were consumers in states where home health agencies competed against each other.

We have learned from these matters and others that CON laws have the potential to impede competition in ways well beyond what is intended by their supporters.

III. Conclusion

My remarks are intended to convey to you our belief that CON laws impose substantial costs on consumers and healthcare markets. In light of these costs, the Antitrust Division believes that Alaska should carefully consider whether on balance its CON laws do more harm than good. Let me close by encouraging you not to accept without careful scrutiny claims that elimination of CON laws will visit significant harm on your state.

Thank you again for the opportunity to discuss our views on how CON laws affect competition and consumers in healthcare. I would be happy to take your questions.

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[23] Department of Justice Statement on the Closing of the Vermont Home Health Investigation, (Nov. 23, 2005) (available at: http://www.usdoj.gov/atr/public/press_releases/2005/213248.htm).

PREPARED STATEMENT OF
THE FEDERAL TRADE COMMISSION

Before the

STANDING COMMITTEE on HEALTH, EDUCATION & SOCIAL SERVICES

of the

ALASKA HOUSE OF REPRESENTATIVES

on

House Bill 337, "An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; relating to the certificate of need program for certain health care facilities; and providing for an effective date."

Who asked for this? DHSS
who paid for it? noone
Where + how was it done? - Dan Gillman from F.T.C.

February 15, 2008

Did any members of the commission come to Alaska? No

I. Introduction

The Federal Trade Commission (FTC) is pleased to have the opportunity to discuss health care competition, Alaska's certificate of need (CON) laws, and Alaska House Bill 337 (H.B. 337), which would modify certain of Alaska's CON laws.[1] The Commission believes that CON laws such as Alaska's can be a barrier to entry to the detriment of health care competition and health care consumers, and that the legislature should consider their repeal. The Commission's conclusion is based on the joint FTC/Department of Justice (DOJ) report, *Improving Health Care: A Dose of Competition* (Report or FTC/DOJ Report),[2] its underlying research, and recent work by FTC staff and the staffs of our sister agencies, such as DOJ and the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services. As noted in the FTC/DOJ Report, "[t]he Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[3]

Congress has charged the Commission with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[4] Pursuant to its statutory mandate, the FTC seeks to identify business practices and regulations that

[1] The FTC initially was invited to submit testimony regarding H.B. 337, as introduced on January 22, 2008, which would have repealed Alaska's CON requirements generally; a more recent committee substitute draft also before the relevant Alaska house committee (but not yet available publicly) would repeal only certain of Alaska's CON requirements, but leave others – such as those regarding nursing homes – intact.

[2] FEDERAL TRADE COMMISSION & THE DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July, 2004) [hereinafter "IMPROVING HEALTH CARE"].

[3] *Id.* at Executive Summary, p. 22.

[4] Federal Trade Commission Act, 15 U.S.C. § 45.

impede competition without offering countervailing benefits to consumers. For several decades, the FTC and its staff have investigated the competitive effects of restrictions on the business practices of health care providers.[5] Included in that general body of health care competition work have been hearings, studies, and reports addressing issues raised by CON laws.

Specifically, the FTC/DOJ Report discusses critically the role of CON laws in health care competition, both as a distinct policy issue and as an important component of other health care competition issues, such as entry problems in hospital markets. The Report broadly examined the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying the preferences of Americans for high-quality, cost-effective health care. The Report was base n, among other things, joint FTC/DOJ hearings that took place over 27 days from February through October 2003, following a Commission-sponsored workshop on health care issues in September 2002. The FTC and DOJ heard testimony from about 240 panelists, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from antitrust and economics to health care quality and informed consent. Together, the hearings and workshop elicited written submissions from interested parties. Almost 6,000 pages of transcripts of the hearings and workshop and all written submissions are available on the Commission website, www.ftc.gov. In addition, FTC and DOJ staffs undertook independent research for the Report.

[5] *See* Federal Trade Commission, *FTC Antitrust Actions in Health Care Services and Products* (Oct. 2003), *available at* http://www.ftc.gov/bc/hcupdate031024.pdf.

In this testimony, the Commission focuses specifically on a few of the issues discussed in the Report that address CON laws and new entry into competition among health care facilities. Three main points require attention:

- First, vigorous competition among healthcare providers, such as hospitals, clinics, and nursing homes, usually benefits consumers through better and more varied services and, in some cases, lower prices. CON laws were designed to create barriers to entry for new healthcare facilities or providers to contain the costs of healthcare services. CON laws, however, have not been particularly effective in controlling healthcare costs, while posing significant risks to competition. In particular, CON laws can retard the entry of firms that could provide higher quality services or lower prices than those offered by incumbents, depress consumer choice between qualitatively different treatment options or settings, or reduce the pressure on incumbents to improve qualitative aspects of their own offerings. Policymakers would be wise to consider reviewing all of the actual costs, benefits, and consequences – intended and unintended – of a regulatory system when assessing that system's future.
- Second, the CON regulatory system creates both the incentive and means by which an incumbent healthcare provider can use the regulatory system itself to delay effective competition, independent of the demand for additional healthcare services. This additional loss of competition is another regulatory cost that must be weighed in the balance when assessing the public interest.

- Finally, Alaska currently has one of the most stringent CON laws in the United States. House Bill 337's proposed amendment of this law would eliminate or reduce barriers to entry for a broad range of healthcare service providers, including small entities that might then be able to thrive as never before.

These points are addressed more fully, below.

II. Discussion

A. Provider Competition Generally: Competition has important benefits in health care services markets, just as it has in the multitude of markets in the U.S. economy that rely on competition to maximize the welfare of consumers. Competitive pressures can lead hospitals and other entities to lower costs, improve quality, and compete more efficiently. In particular, competitive pressure may spur new types of competition. In some hospital markets, new entrants specialize and provide only a limited portion of the in-patient and out-patient services that general hospitals tend to provide.[6] Elsewhere, health care services once delivered only in large hospitals – and requiring overnight stays – may be performed more conveniently and less invasively, at lower cost, in outpatient settings. In addition, both traditional providers and new entities have explored new means to expand access to basic health care by, for example,

[6] *See generally Prepared Statement of the Federal Trade Commission, Before the S. Subcomm. On Federal Financial Management, Gov't Information and Int. Security of the S. Comm. on Homeland Security and Governmental Affairs, on New Entry into Hospital Competition* (May 24, 2005) (regarding, e.g., new specialty hospital entry), *available at* http://www.ftc.gov/os/2005/05/052405newentryintohospitalcomp.pdf; *see also* UNITED STATES DEPT. OF HEALTH AND HUMAN SERVICES, FINAL REPORT TO THE CONGRESS AND STRATEGIC IMPLEMENTING PLAN REQUIRED UNDER SECTION 5006 OF THE DEFICIT REDUCTION ACT OF 2005 (2006) [hereinafter "HHS FINAL REPORT"], *available at* http://www.cms.hhs.gov/PhysicianSelfReferral/06a_DRA_Reports.asp

establishing limited service clinics that can provide more convenient and lower cost care and bring more consumers into contact with the larger health care system.[7]

Although new strategies for lowering costs and enhancing quality are emerging, competition is not as effective as possible in most health care markets, because the prerequisites for competitive markets are not fully satisfied. Of particular concern for today's purpose is the extent to which state regulations can create barriers to entry in health care markets, without conferring countervailing benefits in quality of care or cost containment.[8]

At the same time, the empirical evidence generally does not indicate that CON laws control health care costs.[9] Recent broad studies analyzing both national and state

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[7] *See, e.g.*, FTC Staff Comment Before the Massachusetts Department of Public Health Concerning Proposed Regulation of Limited Service Clinics, 1-2 (Oct. 2007).

[8] In discussing competition concerns raised by CON requirements, the Commission does not mean to suggest that state CON regulations are the only regulatory impediments to competitive forces in health care markets. For example, in testimony before the House Committee on Energy and Commerce on May 12, 2005, Mark McClellan, then Administrator of CMS, reported that CMS, following its own study of specialty hospitals pursuant to congressional direction, would analyze and reform its payment rates "to help reduce the possibility that specialty hospitals may take advantage of imprecise payment rates in the inpatient hospital prospective payment system" and "to diminish the divergences in payment levels [for ambulatory surgical centers] that create artificial incentives for the creation of small orthopedic or surgical hospitals." *Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, Before the H. Comm. on Energy and Commerce Hearing, "Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care,"* (May 12, 2005), *available at* http://www.hhs.gov/asl/testify/t050512.html; *see also Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, on Physician-Owned Specialty Hospitals Before the S. Finance Comm.* (May 17, 2006), *available at http://www.hhs.gov/asl/testify/t060517b.html*.

[9] IMPROVING HEALTH CARE, *supra* note 2, at Ch. 8, at pp. 1-6. Although the larger body of CON literature – including anecdotal reports and small, uncontrolled studies – presents somewhat mixed conclusions on cost savings, the conclusions of the FTC/DOJ Report and staff research have substantially been borne out by more recent, sophisticated large-scale data analyses and literature reviews. "[O]n balance, the most methodologically sound studies have found that CON has no effect or actually increases both hospital spending per capita and total spending per capita." CHRISTOPHER J. CONOVER & FRANK A. SLOAN, EVALUATION OF CERTIFICATE OF NEED IN MICHIGAN, CENTER FOR HEALTH POLICY, LAW AND MANAGEMENT, TERRY SANFORD INSTITUTE OF PUBLIC POLICY, DUKE UNIVERSITY, A REPORT TO THE MICHIGAN DEPT. OF COMMUNITY HEALTH, 30 (May 2003) (reviewing literature and discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws) (hereinafter "CONOVER & SLOAN, REPORT TO MICHIGAN"), WASHINGTON STATE JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE (JLARC), EFFECTS OF CERTIFICATE OF NEED AND ITS POSSIBLE REPEAL, I (Jan. 8, 1999) ("The study found that CON has not controlled overall health care spending or hospital costs

data reveal "little evidence that CON results in a reduction in costs and some evidence to suggest the opposite."[10] Studies also fail to show any consistent increase or surge in health care spending when states remove or modify their CON requirements.[11]

Barriers to entry can affect qualitative competition as well. As the Report noted, state CON laws can retard the entry of firms that could provide higher quality services than those offered by incumbents.[12] That may tend to depress consumer choice between qualitatively different treatment options or settings,[13] or it may reduce the pressure on incumbents to improve qualitative aspects of their own offerings

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The study generally found either conflicting or limited evidence about the effects of CON on the cost of non-hospital services, and on the quality and availability of the various health care services.") DANIEL SHERMAN, FEDERAL TRADE COMMISSION, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS, iv, 58-60 (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data on 3,708 hospitals, that strong CON programs do not lead to lower costs but may actually increase costs); MONICA NOETHER, FEDERAL TRADE COMMISSION, COMPETITION AMONG HOSPITALS 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); KEITH B. ANDERSON & DAVID I. KASS, FEDERAL TRADE COMMISSION, CERTIFICATE OF NEED REGULATION OF ENTRY INTO HOME HEALTH CARE: A MULTI-PRODUCT COST FUNCTION ANALYSIS (1986) (economic study finding that CON regulation led to higher costs, and that CON regulation did little to further economies of scale). *But c.f.*, COMMONWEALTH OF VIRGINIA, REPORT OF THE JOINT COMMISSION ON HEALTH CARE, HOUSE DOC. NO. 82, STUDY OF VIRGINIA'S CERTIFICATE OF PUBLIC NEED (COPN) PROGRAM PURSUANT TO HB 1302 OF 1996 (1997). ("There is little evidence of significant COPN impact on aggregate health expenditures, but there is evidence of savings for specific services covered by COPN."). *Id.* at 1, *available at* http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD821997/$file/HD82_1997.pdf?best_scan_129F6A3CDB83467E=xLesewMDZ3sPV18TLUnlHFQAAAD+Q50W&best_scan__rename=HD82_1997.pdf (last checked 1/31/08).

[10] CONOVER & SLOAN, REPORT TO MICHIGAN, *supra* note 9 at vii (discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws); *id.* at 30-31.

[11] CONOVER AND SLOAN also report that, "[i]n most states that lifted CON, per capita spending on hospital and physician services (relative to the US) has remained below the U.S. average following removal of CON.") *Id.* at 50; *see also* Christopher J. Conover and Frank A. Sloan, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL'Y & LAW 455 (1998) ("no evidence of a surge in acquisition of facilities or in costs following removal of a CON.") 458.

[12] IMPROVING HEALTH CARE, *supra* note 2, at C. 8, p. 4 (citing Hosp. Corp. of Am., 106 F.T.C. 361, 495 (1985) (Opinion of the Commission) (stating that "CON laws pose a very substantial obstacle to both new entry and expansion of bed capacity in the Chattanooga market" and that "the very purpose of the CON laws is to restrict entry").

[13] With regard to hospital markets, *see, e.g.*, HHS FINAL REPORT, *supra* note 6, at 10 (reporting "quality of care at least as good as, and in some cases better than, care provided at local competitor hospitals" for

B. Incumbent Lobbying and Petitioning Protections: When new firms threaten to enter a market, incumbent firms may seek to deter or prevent that new competition. Such conduct is by no means unique to health care markets; it is a typical reaction of incumbents to possible new competitors. In certain circumstances, such conduct may violate the antitrust laws.[14] Certain anticompetitive conduct may, however, be shielded from antitrust scrutiny. The *Noerr-Pennington* doctrine immunizes from antitrust liability conduct that represents petitioning the government, even when such petitioning is done "to restrain competition or gain advantage over competitors."[15] Moreover, the state action doctrine shields from antitrust scrutiny many of a state's own activities when a state government is acting in its sovereign, legislative capacity.[16]

In the context of health care competition, the combination of these two doctrines can offer antitrust immunity to providers that wish to lobby state officials to impede the entry of potential competitors, by denying or delaying the CONs required for operation. State CON programs generally prevent firms from entering certain areas of the health

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cardiac care, as well as "very high" patient satisfaction in cardiac hospitals and orthopedic specialty hospitals) (citations omitted). In addition, specialty hospitals appear to offer shorter lengths of stay, per procedure, than peer hospitals. *See* MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS, 15-17 (Mar. 2005) (hereinafter MEDPAC REPORT). MedPAC was directed to report to Congress on certain issues regarding specialty hospitals under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. *Id.* at vii.

[14] *See* IMPROVING HEALTH CARE, *supra* note 2, at 15-16, ch 1, at 31-33, ch 3, at 22-27.

[15] Andrx Pharm. V. Biovail, 256 F.3d 799, 817 (D.C. Cir. 2001), *cert. denied*, 122 S. Ct. 1305 (2002). The doctrine is named for the seminal cases that treated it: Eastern R.R. Presidents Conference v. Noerr, 365 U.S. 127 (1961), and United Mine Workers v. Pennington, 381 U.S. 657 (1965).

[16] Parker v. Brown, 317 U.S. 341, 351 (1943). The state action doctrine also immunizes from antitrust scrutiny the actions of other entities and individuals if they are acting in furtherance of a clearly articulated state policy and are actively supervised by the state. *See, e.g.*, California Retail Liquor Dealers Assn. v. Midcal Aluminum, 445 U.S. 97, 105 (1980).

care market unless they can demonstrate to state authorities an unmet need for their services. Because that demonstration can be time-consuming and costly, it may delay or, at the margin, prevent the introduction of certain needed facilities and services.[17] Indeed, limiting competitor entry and raising competitors' costs may both be incentives for incumbents to seek to abuse the regulatory process. The FTC/DOJ Report concluded that "incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market."[18] To the extent they are successful in doing so, incumbents may preserve their market shares and revenue streams without enhancing their own operating efficiency or providing health care savings to the state or its consumers.[19]

C. **The Scope of Alaska CON Law:** Alaska's current CON law is among the most stringent of such laws in the United States. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974,[20] which offered states powerful incentives to enact laws implementing CON programs.[21] By 1980, all states except Louisiana had done so.[22]

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[17] *See, e.g.*, IMPROVING HEALTH CARE, *supra* note 2, at C. 4, p. 25 (noting that approval of a CON "can take anywhere from 18 months to several years," and that regulatory delays from CON approval are in addition to those imposed by, for example, traditional licensing requirements).

[18] *Id.* at Exec. Summ., at 22.

[19] *See, e.g.*, MEDPAC REPORT at 10-11 ("Some community hospital administrators admit that competition with specialty hospitals has had some positive effects on community hospitals' operations.")

[20] Pub. L. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k-300n-5), *repealed*, Pub. L. 99-660, § 701, 100 Stat. 3799 (1986).

[21] *See* JOHN MILES, 2 HEALTH CARE & ANTITRUST LAWS: PRINCIPLES & PRACTICE § 16-1, at 16-2 (2003) (noting that the federal Health Planning Act required providers to "obtain state approval – a 'certificate of need' – before spending set amounts on capital investments or adding new health care services.")

[22] *See, e.g.*, *On Certificate of Need Regulation: Hearing on H.B. 332 Before the Senate Comm. On Health and Human Services* (Ohio 1989) (Statement of Mark D. Kindt, FTC Regional Director).

Congress repealed the federal law in 1986, however, and many states have repealed or revised their CON laws in the years since. Fourteen states have eliminated their CON requirements altogether[23] and, although a substantial number of states continue to maintain CON programs,[24] they do so "often in a loosened form compared to their predecessors."[25] Remaining CON laws may address only specific types of health care facilities – such as hospitals or nursing homes,[26] – exempt certain types of health care facilities,[27] or apply broadly to health care facilities improvements of a greater magnitude.[28] In addition, certain CON laws may be pending repeal according to a sunset provision.[29]

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[23] *See, e.g.*, National Conference of State Legislatures, *Certificate of Need: State Health Laws and Programs* (updated Nov. 2007) (CON laws repealed or not in effect in CA, AZ, NM, TX, KS, CO, UT, WY, ID, SD, ND, MN, IN, and PA), *available at* http://www.ncsl.org/programs/health/cert-need.htm (last checked 01/25/08).

[24] MILLS, *supra* note 21, § 16.2, at 16-9 (stating that "CON laws remain in many states and the District of Columbia"). Quite recently, Florida exempted from CON requirements new adult open-heart surgery and angioplasty programs at general hospitals and the addition of beds to existing hospital structures. Fla. Bill S1 01740 (effective July 1, 2004), *amending* FLA. STAT. ch. 408.036, .0361 (2003).

[25] MILLS, *supra* note 21, § 16.1, at 16-2 to 16-3. *See also* Len M. Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning*, 23 HEALTH AFFAIRS 1, 11 (Mar./Apr. 2004) (noting that CON programs "eroded through the 1990s").

[26] *See, e.g.*, OAC Ann. 3701-12-05 (2007) (regarding only certain activities by "long-term care" facilities in Ohio); R.R.S. Neb. § 71-5829.03 (2007) (CON covers only certain activities related to long-term care and rehab beds in Nebraska); ORS § 442.315(1) (2005) (regarding "any new hospital or new skilled nursing or intermediate care service or facility" in Oregon, subject to certain exclusions).

[27] For example, Connecticut law exempts critical access hospital beds and related equipment from the State's CON laws. *See* Conn. Gen. Stat. § 19a-487a (2007); *see also* Fla. Stat. § 408.0361 (2007) (regarding cardiovascular services and burn unit licensing); Fla. Stat. § 408.036 (2007).

[28] For example, Connecticut health care facilities must obtain a CON prior to developing, expanding or closing certain services and expending more than $3 million on a capital project. Conn. Gen. Stat. § 19a-638(a)(4) (2007). Delaware requires a CON for the establishment of a new facility, but only for capital expenditures by existing facilities in excess of $5.8 million (or a higher amount based on inflation adjustments to the $5.8 million baseline). See 16 Del. C. § 9304 (2007).

[29] *See, e.g.*, 16 Del. C. § 9311 (2007) (sunset provision).

Alaska law requires a CON for any type of health care facility construction or improvement of $1,000,000 or more, adjusted,[30] or the establishment of a nursing home facility independent of that cost threshold.[31] In so doing, it places significant regulatory burdens on the development or improvement of a very broad class of health care facilities – not just major hospital initiatives and expansions, which may be subject to long-term planning – but diverse outpatient clinic initiatives, which might otherwise develop dynamically in response to market needs. The scope of current Alaska law thus stands in contrast not only to the laws of those states that have eliminated their CON requirements altogether, but the laws of the many states that have more limited CON requirements. Alaska's low CON threshold itself may be a special burden to the State's health care spending, as low CON thresholds have been observed to increase costs – relative to higher thresholds – rather than decrease them.[32]

A degree of controversy may remain about particular issues addressed by certain CON laws. These include, for example, efficiency and possible conflicts of interest concerns about certain categories of physician-owned specialty hospitals and access issues for rural or other underserved areas.[33] However, the sweep of Alaska's CON law

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[30] Alaska Stat. § 18.07.031(a) (2007). The statute contains an adjustment provision, whereby the $1 million dollar threshold may be increased by $50,000 per annum, between 2005 and 2014. *Id.* at § 18.07.031(d).

[31] *Id.* at § 18.07.031(b).

[32] *See* SHERMAN, *supra* note 9, at 58-60 (1.4 percent decline in costs associated with doubling of all thresholds).

[33] *See, e.g.*, Testimony of Mark B. McClellan, M.D., Ph.D. (2005), *supra* note 8; Testimony of Mark B. McClellan, M.D., Ph.D. (2006), *supra* note 8 (regarding CMS studies of physician-owned specialty hospitals, implementation and termination of limited moratorium on new specialty hospitals). The Commission does not here intend to analyze the details of ongoing regulatory reform at CMS designed to address special concerns about certain limited types of specialty hospitals (and related physician self-referral issues) or the various bodies of research on which those reforms are based. The FTC notes, simply,

is much broader than required to address any of those more narrow and complex issues and is likely to be detrimental to Alaska's health care consumers. The Commission recommends that Alaska carefully consider the evidentiary basis of these issues as they may relate to Alaska health care consumers. If the evidence and public policy considerations warrant some legislative action, the Commission recommends that Alaska consider regulation that is narrowly tailored to achieve focused health policy goals instead of broad regulation of entry into the market for health care facilities.

III. Conclusion

CON laws were adopted throughout most states under particular market and regulatory conditions substantially different from those that predominate today and were intended to help contain health care spending. The best available research does not support the conclusion that CON laws actually reduce such expenditures. As the FTC and DOJ have said, "on balance, CON programs are not successful in containing health care costs, and . . . they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[34] CON laws tend to create barriers to entry for health care service providers who may contribute to qualitative competition and provide consumers with important choices in the market, but CON laws do not, on balance, tend to suppress health care costs or aggregate health care spending. Moreover, CON laws may be especially subject to abuse by incumbent providers, who can seek to exploit a state's CON process to forestall the entry of competitors in their markets.

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that most of the actual and potential health care entities subject to Alaska CON law are not such specialty hospitals and appear to fall outside the concerns driving those studies and reforms.

[34] IMPROVING HEALTH CARE, *supra* note 2, at Executive Summary, p. 22.

Alaska's current CON law – which House Bill 337 seeks to modify – is among the most stringent of such laws in the United States. As a consequence, Alaska CON law creates a barrier to entry for a very broad range of health care service providers, including small health care entities that may be ill-equipped to overcome it. The Commission believes that both the breadth of Alaska's CON law, and its low threshold, are of special concern, as they may work to the detriment of Alaska health care consumers. In the event that adequate evidence develops to support more narrow policy priorities, the Commission believes that Alaska should consider regulations narrowly tailored to meet those priorities, while minimizing the general costs to Alaska health care consumers.

diagnostic
health Anchorage
Discover Excellence in Radiology

March 11th, 2008

AK State Capitol
House Finance Committee
Juneau AK 99801-1182

Dear Representative Chenault, Representative Meyer, Representative Stolze and other House Finance Committee members

As an AK resident and healthcare administrator I implore you not to consider any legislation or portion thereof (i.e. HB 327, HB 337A/B, and HB 345), which recommends removal or modification of AK's Certificate of Need (CON) program. Thorough and unbiased research needs to be accomplished prior to any such action given the potential negative impact such legislation would have on the safety and quality of AK's healthcare.

I currently serve as the AK Area Administrator for Diagnostic Health and directly oversee a full modality outpatient imaging center located in midtown Anchorage[1]. As a healthcare administrator with over 15 years of experience, I have grave concerns regarding current legislation in the Senate and House to eliminate or modify AK's CON program. I strongly urge unbiased research/study to determine the full short-term and long-term impact before any such action is taken. Some particulars which need to be contemplated are as follows:

- Thirty-six states still maintain some form of a Certificate of Need program. Many of the states that repealed their laws in the 80s and 90s experienced a proliferation of facility development and major medical equipment acquisition. This is particularly disturbing given that "supply" for outpatient imaging services (in the Anchorage area) is currently greater than "demand."
- Removing/modifying AK's CON program could have an extremely negative outcome with regard to quality of care as many freestanding imaging centers would not bother to hire registered technologists or ensure their facility is accredited. The American College of Radiology is conscious of this fact and thus tends to favor tighter CON restrictions for imaging services.
- Removing/modifying AK's CON program would certainly have an immediate and possibly long-term impact on the availability of skilled labor (registered technologists) causing shortages in many fields/modalities with the strong probability of negatively impacting the safety and quality of AK's healthcare.
- Market and business-driven healthcare in AK is idealistic but not a reality. It's a contradiction for some to say that "health care must be market-and business-driven, rather than restricted by government" when reality illustrates that healthcare is the most

[1] Diagnostic Health Anchorage LP (formerly HealthSouth Diagnostic Center of Anchorage LP) has been providing full modality outpatient imaging services in a timely, quality, and cost-effective services to AK residents for over 10 years.

heavily regulated industry and that government dictates a significant portion of most healthcare entities reimbursements.

As a member of the CON Negotiated Regulation Making Committee (Oct/Nov 2007) I had hopes that state officials would use the Committee's recommendations in making the necessary changes to AK's CON program. I can attest that the Committee was a solid cross-sectional representation of our state's finest healthcare leaders. As you are aware, reaching 100% consensus whether it be the Committee or AK Legislature is never accomplished. Therefore, the Committee agreed upfront that 66% or greater was the determinate number to say that a consensus was reached, if 70% or higher was reached the decision would be considered a high consensus. What was amazing is that 88% of the committee determined that the state of AK needed to retain the CON program; 83% determined that imaging services needed to remain in the CON requirements. An important point to highlight is that the Achilles Heal for the state is not the CON program itself. The Achilles Heal has been the inability to define in regulation what a "physician office" is. Not adequately defining physician office has created a tremendous amount of litigation for the state. Realizing the import of this issue, the Committee clarified the definition of physician office with 71% of the committee stating that a physician office should be 100% physician owned." What perplexed me and other healthcare providers who took their valuable time to participate in the CON Negotiated Rule Making Committee is that our recommendations to address the obvious CON issue didn't seem to satisfy our Governor or the Commissioner of the Department of Health and Human Services. Within weeks of the Committee's final report, the Governor introduced the Alaska Health Care Transparency Act of which a component there within proposes to completely repeal the CON program.

I appreciate some aspects of the AK Health Care Transparency Act; however, repealing or modifying the Certificate of Need program at this time would be premature and could have severe negative consequences to the safety and quality of Alaska's healthcare. I urge AK Legislatures to table any discussion regarding the CON program until unbiased research and recommendations are provided. Please contact me if you have any questions or concerns at ward.hinger@dxhealthcorp.com or (907) 729-5854.

Sincerely

Ward Hinger
AK Area Administrator for Diagnostic Health

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
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February 25, 2008

Honorable Peggy Wilson, Chair
House Health, Education, and
Social Services Committee
Alaska State Capitol, Room 403
Juneau, AK 99801-1182

RE: House HES Committee questions on House Bill 337, House Bill 345, House Bill 407

Representative Wilson:

In response to questions raised by the House Health Education and Social Services Committee on Saturday, February 23, 2008:

Questions regarding Certificate of Need:

Please clarify how capital costs play into rates and how CON controls the rates for RPTC and Nursing Homes.

For nursing homes, CON approved capital costs for projects with approved capital costs over $5 million are included in the calculation of payment rates immediately upon the new project beginning normal operations. For CON approved projects costing less than $5 million, the approved CON capital costs are included in the calculation of rates when the individual facility's payment rate is rebased. If a project that requires a CON does not receive an approved CON, those costs are never included in the Medicaid payment rate.

To clarify, CON controls the Medicaid rates for Nursing Homes by only including capital costs to be included in the Medicaid cost-based rate if a required CON has been approved, and initially only to the capital costs approved in the CON.

And, currently, CON does not directly affect the Medicaid payment rates for RPTC. RPTC payment rates are based on cost studies that include consideration of capital costs, but those rates are not based upon whether or not an RPTC has an approved CON.

When using a specific threshold for population base, as in HB345 at 60,000, do we need to define so that it is clear whether it includes military and tribal?

We should define the population in statute so it is clear either way. The department believes we should exclude IHS and Military in CON population threshold.

Questions on information collected by the Information office and disseminated on the state Web Site:

Do we want an amendment whereby physicians would need to report costs/rates to the health information office for posting on the Web site?

We will need to make sure that the Information Office has the authority to collect such information; should the committee wish to have this information collected and on the Web site, it should be clarified in statute.

Do we want an amendment that indicates who accepts Medicaid and Medicare in the information new collect?
We would support having this information on the Web site, although should the committee wish to have this information collected and on the Web site, it should be clarified in statute.

Does the commission have the ability to add to the information collected and provided to the public new services/facility types that have not yet been developed?
There are difficulties in including emergent technologies in the bill – we recommend giving the Commission the option to recommend inclusion of information on new types of services through future statutory changes.

RE: composition of the Health Care Commission
The Administration supports the composition and duties of the Health Care Commission as proposed in HB407. We would support incorporating in those elements into HB337, rather than have the Commission be legislated separately from the Health Information Office and repeal of the Certificate of Need. We still believe that the three parts of HB337 better provide for support to the Commission by the department, and provides for needed change in the Health Care system by repealing Certificate of Need.

Technical amendments:
With the permission of the HES Chair, the Departments of Law and Health and Social Services can work with Legislative drafters to clear up technical problems in the legislation.

Sincerely,

Sherry Hill
Sherry Hill
Assistant Commissioner for Public Affairs

Cc: Representative Paul Seaton, Room 102
Representative Bob Roses, Room 416
Representative Anna Fairclough, Room 411
Representative Wes Keller, Room 24
Representative Sharon Cissna, Room 420
Representative Berta Gardner, Room 422
Karleen Jackson, Commissioner
Dr. Jay Butler, DHSS Chief Medical Officer
Mike Tibbles, Chief of Staff, Governor's Office
Anna Kim, Special Assistant, Governor's Office

Russell Kelly, Director, Governor's Legislative Office

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Certificate of Need Laws: Why It's Time for Repeal

Dr. Roy Cordato
Introduction by Dr. Michael Morrisey

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ALABAMA POLICY
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The Alabama Policy Institute (API) is an independent, non-profit research and education organization that is issue-centered and solution-oriented. We provide in-depth research and analysis of Alabama's public policy issues to impact policy decisions and deepen Alabama citizens' understanding of, and appreciation for, sound economic, social and governing principles.

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Certificate of Need Laws: Why It's Time for Repeal
by Dr. Roy Cordato

Introduction by
Dr. Michael A. Morrisey

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Certificate of Need Laws: Why It's Time for Repeal

Introduction

Dr. Michael A. Morrisey

Certificate of need (CON) is an amazing program that requires hospitals, nursing homes, and usually other medical facilities such as ambulatory surgery centers and diagnostic imaging facilities to have the explicit approval of the state before they can operate. It originated in New York State in 1964 and became national policy during the Richard Nixon administration. The legislation was intended to control rising healthcare costs that resulted from cost-based reimbursement. CON was repealed as national policy during the Reagan administration -- some 20 years ago.

What is amazing is that there is virtually no rigorous empirical evidence that the program has been effective in reducing hospital or healthcare costs and some evidence that it increases costs. This was true in the heyday of the program in the 1980s and is still true in more recent evaluations. Yet, CON continues to exist for hospitals in Alabama and 25* other states and effectively limits hospital construction and renovation.

In this report Roy Cordato does a masterful job of describing the wonder of CON – the evidence of ineffectiveness, the record of bureaucracy and delay, the stifling of innovation, and the limits to competition in healthcare. It should be read by anyone interested in reducing healthcare costs, increasing competition, thereby empowering healthcare consumers, and reducing unnecessary government agencies.

I want to highlight four points for Alabamians to consider. First, we don't save money as a result of the CON program. There is essentially no evidence that healthcare

* There are 26 states with CON programs for hospitals. There are 35 states with a CON program applicable to some type of medical care facilities and/or equipment

costs are reduced. Cordato carefully documents this. Currently, hospitals and other protected providers argue that CON keeps new providers from coming in and taking the profitable patients. It certainly does. Another way t say this is that the existing providers are collecting prices that are higher than their costs and apparently higher than the new entrants would charge. So, by their own admission, we pay higher prices.

Second, we have less choice and less innovation. In the spring of 2007 our neighbors in Georgia witnessed a long and bitter battle waged in the legislature over amending or repealing its CON law. On one side were hospitals arguing to keep CON intact. On the other side were physician groups arguing to be allowed to open freestanding ambulatory surgery centers and other outpatient facilities without having to go through the burden of the CON process. The hospitals won this battle when the legislature deadlocked and took no action.

Entry of new ambulatory surgical providers is no trivial issue. We all have friends or family members who have had an ambulatory procedure performed that only a few years ago would have required a day or more in the hospital. The American Hospital Association reported that in 2004 there were over 1.7 outpatient surgeries conducted in U.S. hospitals for every one hospital surgery that required an overnight stay.[1] Ambulatory surgery centers represent a competitive alternative to hospitals for these outpatient procedures. Indeed, my research suggests that nationally every freestanding ambulatory center per 100,000 population in a metropolitan area is associated with a reduction of 4.3 percent in the number of hospital-based outpatient procedures.[2] The battle in Georgia was over entry of new providers and choice and ultimately over who gets the patients. As Cordato makes crystal clear in this monograph, in states like

Georgia, North Carolina and Alabama the CON agency plays a big role in deciding who gets the patients and what access those patients have to new technology.

Third, CON is not only focused on keeping out new forms of healthcare delivery, it is also concerned with whether and how existing providers can serve their communities. One need look no further than the burgeoning Highway 280 corridor in Birmingham or the growth in Madison County near Huntsville to appreciate that many people in increasingly congested areas of the state now have longer travel times to get to a hospital. In both communities, existing hospitals (and new providers) would almost certainly be willing to build in the growth corridor. Much of what stops them is the CON process. Any proposed action will be opposed by other hospitals in the community because of the threat to their established patient flow. So, in addition to the usual construction and operating costs, an effort to expand will be tied up with CON hearings, decisions, appeals and more appeals.

There is no better example of provider opposition than Brevard County, Florida, near Cape Canaveral. Wuesthoff Hospital and Health First Hospital have been competitors in this fast growing community for years. In 1997 Wuestoff proposed to build a second hospital. It obtained an CON approval that was opposed by Health First in the courts. It was only in 2000 that Wuesthoff finally cleared the legal challenges and the new facility opened in December of 2002. Ironically enough, Health First Hospital later applied for a CON for its own new hospital. After getting a CON in late 2005, the approval was opposed by Wuesthoff. Health First's final approval was not obtained until April of 2007 and the new facility is expected to open in 2010.[3] Thus, the opposition fostered by the CON process resulted in delays of three years in the first instance and nearly two years in the second. In other cases, undoubtedly the Highway 280 case as well, providers don't even try because of the time and cost of fighting for approval.

Finally, Alabamians needn't be reminded of the embarrassment of a former governor and a former hospital CEO who were convicted in a federal bribery case associated with an appointment to the Alabama CON board. We are not alone, of course. In 2006 a member of the Illinois CON board pleaded guilty in federal court to accepting kickbacks associated with steering business to a construction contractor when a suburban hospital sought a CON approval. He was also charged with being instrumental in denying the application of another hospital that did not hire the contractor.[4]

Regulatory agencies that provide protection from market competition and thereby offer the potential for substantial profits are tempting targets for unscrupulous politicians and bureaucrats. These temptations can be overcome with sufficient monitoring and careful processes, but it seems foolish to go through all of that for a program that doesn't provide benefits to the citizens of the state.

The CON program never controlled costs and has become a mechanism to limit competition in healthcare, making all of us worse off. I encourage you to read Roy Cordato's report and judge for yourself. It's time for repeal.

Michael A. Morrisey is a health economist in the School of Public Health at the University of Alabama at Birmingham. He holds a Ph.D. in economics from the University of Washington and has been a resident of Alabama for over 20 years. He has contributed extensively to the empirical research on the effectiveness of Certificate Of Need. This is written in his private capacity.

Certificate of Need Laws: Why It's Time for Repeal

Dr. Roy Cordato

What's Wrong with this Picture?

Imagine an economic system where market competition is viewed as a wasteful activity that needs to be discouraged or even prohibited by government. In such a system, for example, if a Chinese immigrant family wants to open a restaurant, they first have to go to a government commission that will survey the economic landscape for Chinese restaurants to determine if there already are "enough" such eateries in the area. The commission might have a formula that looks 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 buffets 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 are targeted to the gourmet Chinese food market.

After going through all this--a process that might take several years--the commission will then decide whether this particular Chinese restaurant is "needed" in the area. If it is not, this immigrant family will then be sent packing to find 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" will be issued to the immigrant family. It could 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 will have to be built to the exact specifications described in the original proposal that was ultimately approved. It may not be able to offer take-out service if there are already "enough" take-out restaurants in the area. It will have to be built only to accommodate a certain number of tables because any more or any less will not fit the need as determined by the formula. The menu will have to be approved, because if the restaurant is also going to serve non-Chinese foods such as pizza or hamburgers—for those who might not like Chinese food—that will fall into a different category and those menu items will have to be passed through another formula and another process.

Most people look at such a system and think "this is crazy, only an old 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 have already received one of these highly valued certificates and are operating a flourishing business? Wouldn't 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 Alabama and 35[1] other states have with respect to medical care facilities and equipment. If you are a healthcare 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" from the state. The function of Alabama's CON is summarized as follows:

"No certificate of need for new inpatient facilities or services shall be issued unless the State Health Planning and Development Agency (SHPDA) makes each of the following findings:

1) That the proposed facility or service is consistent with the latest approved revision of the appropriate state plan effective at the time the application was received by the state agency;
2) That less costly, more efficient, or more appropriate alternatives to such inpatient service are not available, and that the development of such alternatives has been studied and found not practicable;
3) That existing inpatient facilities providing inpatient services similar to those proposed are being used in an appropriate and efficient manner consistent with the community demands for services;

[1] See footnote on page 1

4) That in the case of new construction, alternatives to new construction (e.g., modernization and sharing arrangement) have been considered and have been implemented to the maximum extent practicable; and
5) That patients will experience serious problems in obtaining inpatient care of the type proposed in the absence of the proposed new service."[5]

If this sounds like the kind of central planning one might find in a socialist economy—it is. In Alabama, the central planning authority is known as the State Health Planning and Development Agency (SHPDA) 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 HPDA 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 of 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 of 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 deemed to be reasonably necessary to determine compliance.

Alabama'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 healthcare facilities. 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 is appealed to the state Court of Appeals, the process can go well beyond this two-year period.

It is quite clear that most important aspects of the production, distribution, and sale of healthcare services in Alabama, 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 Alabama, 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 healthcare 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 healthcare 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 healthcare 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. 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 is not 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 shortcomings in accurately estimating 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. These, in turn were 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 Medicare cost-based reimbursement system and switched to paying a predetermined amount based on the kind of treatment. Since that time, 14 states have dropped their CON program, allowing for competition. Alabama is one of 36 states, plus the District of Columbia, that continues with centralized planning of the healthcare-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:[6]

- 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 a 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 Garena, writing for the Federal Reserve Bank of Richmond, these pre-mandate laws were implemented "in response to hospital operators who favored centralized health planning."[7] This is consistent with the economics of CON, to be discussed below, which suggests that in reality, CON is a cartel enforcement device that protects 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."[8] 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 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.

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 the intent is that MRI services should be less expensive, we should have fewer MRI machines; or if we want hospital stays to be cheaper, we need fewer hospital rooms. As pointed out by The National Academy of 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."[9] But it is just as wrong-headed to think that limiting the supply of healthcare equipment and facilities can reduce healthcare costs as to think that oil prices could be reduced 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 healthcare providers are no exception--stimulates new technologies and innovative and more efficient ways of delivering goods and services to 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 above who wish to provide MRI services, are always looking for ways to outperform existing providers.

As noted, CON laws turn the simple economic truths about the relationships 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 explain why an actual free market in medical care facilities and equipment would not behave as economic theory would predict. Instead 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 (which I discuss in the next section), 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."[iii] This would be comparable to complaining that much of medicine and the analysis of patients' conditions by doctors is also mistakenly 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 Alabama'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 *overutilization* of healthcare services."[11] [Emphasis added] First, note the presumptuous and paternalistic attitude of the legislators formulating this statement. They claim to know better than healthcare consumers, their doctors, and facility operators, how "necessary" facilities are and that these market participants are "overutilizing" the healthcare that is available to them.[12] 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 "*overutilization* of healthcare services."

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. This is essentially the debate going on before an administrative law judge in Montgomery. Which hospital, Crestwood Medical Center or Huntsville Hospital, will be allowed to build a new facility in the fast growing Huntsville, AL market?[13]

Apparently, some state bureaucrats, who are not market participants themselves, believe there would be excess capacity if new providers are allowed to enter the market. 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. New facilities and services would lead to more choices for patients and more competition for their healthcare dollars. Indeed, at the lower prices that could be generated, people who might forgo health exams for less expensive, but also less effective methods of diagnosis may be able to take 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 healthcare 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 healthcare costs as states eliminated their laws. If CON were "working" as advertised, then one would expect to see a rise in healthcare costs when the laws were eliminated. But 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.*[14]

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 modest 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 healthcare 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 nine percent increase in spending on other healthcare. Overall, the study found that CON was responsible for a 13.6 percent increase in per capita spending on personal healthcare services.[15]

Over the last two decades, the FTC 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 healthcare costs, there is considerable evidence that they can actually drive up prices by fostering anticompetitive barriers to entry."[16]

In 1989, similar testimony was given to the North Carolina Goals and State Pol 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."[17] 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."[18]

CON as a Hidden Healthcare 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 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."[19]

What this means is that CON laws are used to create a hidden tax. The cost of healthcare and the profits to healthcare providers are purposely kept high by granting monopoly privileges. It is then expected that these excess profits will be used to provide free healthcare to the indigent. Healthcare 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 healthcare 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 healthcare services should bear the burden of also paying for care given to the indigent, then an explicit excise tax should be placed as a line item on all healthcare 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 healthcare system relates to the resources hospitals and other healthcare entrepreneurs must devote to obtaining the certificate. The process of obtaining a CON is not only time consuming but expensive. The ill-fated U.S. Highway 280 "hospital" in Birmingham provides an excellent example. The facility stands empty in large part because no new private entity believes they can obtain a CON and no current market participants believe it is worth the fight with its sister hospitals to try to open a new hospital in the high growth 280 corridor. The experience in Madison County, near Huntsville is also instructive. Local Huntsville hospitals are "competing" to get the SHPDA, the Alabama CON agency to designate one and only one of them as having the right to build a new facility.

Healthcare Policy: Breaking the Consumption/Payment Link

Is healthcare 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 healthcare 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 healthcare expenses. In 2002 over 84 percent of all personal healthcare expenditures were made by someone other than the person receiving the care.[20] Unlike the market for other goods and services, healthcare 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 healthcare plan. Hence, the "consumption/payment link" that is typical of most other buyer/seller arrangements, is broken in the healthcare market.

How is healthcare like an all-you-can-eat buffet or a free shopping spree?

This arrangement causes healthcare to be overpriced because it leads to healthcare 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 "overeat" at all-you-can-eat buffets. It also explains why, when crab legs or sirloin steaks are on the buffet, people will tend to consume relatively more of those items than the hot dogs or beans.

Imagine a grocery store operating like the healthcare system. Instead of walking up and down the isles 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 would drive to the local supermarket and pay 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 happened for decades in the healthcare market.

The Problem of Low Deductibles

The fact that many plans have low deductibles with routine healthcare problems being paid by insurance, rather than only high-cost operations and catastrophic conditions also fuels the costs of healthcare. In the 1940s, '50s, and '60s, most people referred to healthcare 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 healthcare, but a failed set of government policies. As noted, most people do not pay directly for their own healthcare, but it goes beyond that. They don't even pay directly for, or even own their own health insurance policy, like they do with auto or homeowners insurance. Taxpayer-funded programs like Medicare and Medicaid pay nearly 45 percent of all healthcare bills.[21] 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 is related to the way health insurance is treated for income tax purposes. The tax code penalizes the individual ownership of health 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.[22] 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 an overuse of health insurance and healthcare services.

There is some good evidence that competition actually has worked in healthcare. The evidence comes from the workings of managed care in the first half of the 1990s. Now most people tend to think of managed care as their primary care gatekeeper denying them access to a specialist or to a longer hospital stay or to a particular drug. Managed care plans have done these things – but ironically there is remarkably little evidence that these activities lowered costs.

However, the real contribution of managed care was (and is) selective contracting, not these ineffectual utilization controls. Managed care plans negotiated contracts with hospitals and other providers based upon quality, and location *and price*. What the evidence shows is that when there were more hospitals in a market, the managed care plan was able to negotiate lower prices. Given the number of hospitals, when there was more idle capacity in the market, the managed care plans were able to get still lower prices. The managed care plans were also able to get lower prices when they had a larger number of enrollees in the market. Thus, consistent with orthodox economics, managed care plans were able to use patient volume to drive lower prices – and this process was more successful when there were more providers in the market.[33] The "managed care backlash" has focused on the utilization controls and ignored the selective contracting with the result that we moved from declining health insurance premiums in the mid 1990s to increasing premiums today.

A public policy answer to this problem is arriving, albeit tentatively and slowly, in the form of "health savings accounts" (HSA), 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 healthcare 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 healthcare expenses. The important point is that any amount from this account not spent remains the property of the employee, to be used for either future healthcare problems, retirement income, or to leave to their children and grandchildren.

This approach reconnects consumption and payment for most routine healthcare-related costs. A dollar spent on healthcare services now is a dollar that cannot be used later. As in other areas of income allocation, people will consider tradeoffs. By partially reconnecting the consumption/payment link, HSAs provide people with an incentive to be smarter and more cost-conscious healthcare 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

CON regulations are an attempt at complete central planning of investment in healthcare-related facilities. The underlying premise is twofold. First, that individuals and companies acting in a free market will misallocate healthcare resources. As stated directly in Alabama's CON law, "… will be administered in the state to assure that only those healthcare services and facilities found to be in the public interest shall be offered or developed in the state."[24]

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 healthcare investment, can improve on market results, and better serve the public's healthcare 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 other words, the best judges as to whether the service will be "needed" are the entrepreneurs and investors themselves. 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 healthcare market. Hospitals will continuously re-evaluate their circumstances to determine if new birthing rooms are needed, or an expanded emergency room is necessary, 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 parts of their operations.

On the other hand, CON laws substitute bureaucratic decision-making for the market's entrepreneurial assessments. Government decision-makers have no basis for gathering accurate market information and, furthermore, they have no incentive to make investments 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. In fact, there is no real way of determining subsequently whether or not a proper decision has been made. Conversely, a good entrepreneurial decision is one that accurately assesses healthcare 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 forgone. 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. Bureaucrats who judge CON submissions 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 generating the information.

In his Nobel Laureate lecture, "The Pretense of Knowledge," economist Friedrich Hayek argued that central planners, like those charged with determining who should and should not provide medical services can only "pretend" to have the information necessary to make the kinds of decisions they make.

At best, any determination of "need" by such planners will be arbitrary 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 those hospitals used regulation to keep out competition."[25]

Conclusion

The Federal Trade Commission advises that "states with CON programs should reconsider whether these programs best serve their citizens' healthcare needs." In fact, Certificate of Need Laws in Alabama and other states should be explicitly repealed. State governments should not be aiding and abetting monopolies or their formation, or acting as a cartel enforcement mechanism for established healthcare interests. This is especially true in healthcare markets where competition, which is widely recognized by economists as the most effective tool for driving costs down, is sorely needed. Competition provides the incentives to discover new technologies and new efficiencies for delivering those technologies to patients.

The idea that in the area of healthcare 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 that CON laws and the bureaucrats who administer them can do a better job than the competitive market process is not only wishful thinking, it is the economic equivalent to believing the earth is flat.

Healthcare provision around the world is controlled by varying degrees of government central planning. Consequently, all systems tend to be dominated by different forms of healthcare 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.

Endnotes:

[1] American Hospital Association, *AHA Hospital Statistics* (Chicago: Health Forum, LLC, 2006). page 11.

[2] John Bian and Michael A. Morrisey, "Free-Standing Ambulatory Surgery Centers and Hospital Surgery Volume," *Inquiry* 44(2):200-210 (Summer 2007).

[3] See Michael A. Morrisey, "Certificate of Need: Protecting Providers, Not Controlling Costs," in Allison Lake, ed., *Healthcare in Maryland: A Diagnosis* pp: 67-78 (Germantown, MD: Maryland Public Policy Institute, April 2005) and Health First, "More Good News for Viera Hospital!" http://www/vierahospitalnow.com (last accessed July 26, 2007).

[4] Dana Heupel, "GOP Senators Challenge Health Facilities Planning Board," *State Journal-Constitution* (December 26, 2006) http://www.senategop.state.il.us/index.php?option=com_content&task=view&id=296&Itemid=123 (last accessed July 26, 2007).

[5] Alabama Code 1975 Vol. 14A Section 22-21-266

[6] 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.

[7] Charles Gerena, "Putting on the Brakes," *Region Focus*, Spring 2004, Federal Reserve Bank of Richmond. www.rich.frb.org/publs/regionfocus/spring04/brakes.html

[8] Ellen S. Campbell and Gary Fournier, "Certificate-of-Need Deregulation and Indigent Hospital Care," *The Journal of Health, Politics, Policy and the Law*, Vol. 18, No. 4, 1993, p. 906.

[9] Ellen Jane Schneither, et. al. "Rising Healthcare Costs: State Health cost Containment Approaches," National Academy for State Health Policy, June 2002, p. 4.

[10] See "The Federal Trade Commission and Certificate of Need Regulations: An AHP Critique, January 2005, 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. 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."

[11] Article 9, Certificate of Need, p.1. As will be discussed at length below, healthcare services are over-utilized, not as a result of "the open market" but as interventions that distort the market.

[12] 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

[13] Thomas R. Tingle, "Madison Hospital Decision Looming," *Huntsville Times* (August 29, 2007) www.al.com/news/huntsvilletimes/index.ssf?/base/news/1188378972109080.xml&coll=1

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[14] Op. cit. at note 6.

[15] Joyce A. Lanning, Michael Morrisey 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.*

[16] *Improving Healthcare: A Dose of Competition*, a report by the Federal Trade Commissions and the Department of Justice, July, 2004, *http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf*

[17] From FTC press release found at http://www.ftc.gov/opa/predawn/F89/nc-con.txt.

[18] 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.

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[20] See http://www.census.gov/prod/2004pubs/04statab/health.pdf, table no. 120. "Personal Healthcare Expenditures by Object and Source of Payment: 2002"

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[22] 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.

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Alaska State Hospital and Nursing Home Association

2008 Alaska Hospital Community Benefits Report

Alaska's Hospitals Creating Healthier Communities

Alaska's Hospitals:
Improving Health through Community Benefits

About this Report

The challenges to improving the health of Alaskans are as tall as our mountains and as unique as our topography, climates and communities. Each and every day, Alaska hospitals voluntarily offer programs and services in their communities that exceed traditional daily medical care. These programs and services — called Community Benefits — deliver health care assistance and solutions to specific populations with unique medical needs. The goal of Community Benefits is to improve the health of Alaska by improving the quality of life for Alaskans.

The Alaska State Hospital and Nursing Home Association (ASHNHA) is proud to present the *2008 Alaska Hospital Community Benefits Report*. While many people are familiar with hospitals' role as major employers, this is the first time ASHNHA has quantified and reported to Alaskans the Community Benefits provided by the state's acute care hospitals.

Community Benefits are programs and services that exceed the routine and emergency care provided around the clock daily by Alaska hospitals. Community Benefits are often provided free of charge or at substantially reduced fees. They are targeted programs and services that address the identified and often unique health care, social and welfare needs of the people who live in a particular community. These benefits provide measurable improvements in health status and access to health care for a community's residents. They also provide care to Alaskans regardless of ability to pay.

Sixteen Alaskan hospitals provided data to the *2008 Alaska Hospital Community Benefits Report*. Participating hospitals are Alaska Regional Hospital, Anchorage; Bartlett Regional Hospital, Juneau; Central Peninsula Hospital, Soldotna; Cordova Community Medical Center, Cordova; Fairbanks Memorial Hospital, Fairbanks; Ketchikan General Hospital, Ketchikan; Mat-Su Regional Medical Center, Palmer; North Star Behavioral Health, Anchorage; Petersburg Medical Center, Petersburg; Sitka Community Hospital, Sitka; South Peninsula Hospital, Homer; Wrangell Medical Center, Wrangell; Providence Alaska Medical Center, Anchorage; Providence Kodiak Island Medical Center, Kodiak; Providence Seward Medical & Care Center, Seward;
and Providence Valdez Medical Center, Valdez.

Community Benefits: Saving & Changing Lives

Safe Kids Water Safety Program Saves Lives

Dan Baeten credits his 14-year-old son for saving the lives of his family members after attending the Safe Kids Water Safety community benefit event in Soldotna. The young man's personal flotation device and his knowledge of how to handle a boating accident saved the family when their canoes overturned and were swept down river on a treacherous stretch of water.

WOW Ride Gives Back

Oncology nurse Kathy Lopeman started a fun-filled winter snowmobile fundraiser. The event raised $34,000 to distribute to community members as $1,000 grants for those needing items not covered by insurance or assistance to travel for medical care.

FINDINGS:

ALASKA HOSPITALS PROVIDE $151.6 MILLION IN COMMUNITY BENEFITS

Alaska hospitals provided $151.6 million in Community Benefits to communities and citizens in 2006, the most recent year for which data are available. The hospitals also paid more than $10.3 million in taxes and fees to state and local governments. The data come from surveys completed in January 2008 by 16 Alaska hospitals (see complete list on page 2 under "About this Report.") Community Benefits are programs and services offered by hospitals beyond required daily health care services. They target specific populations in a community with assistance and solutions to unique health care needs.

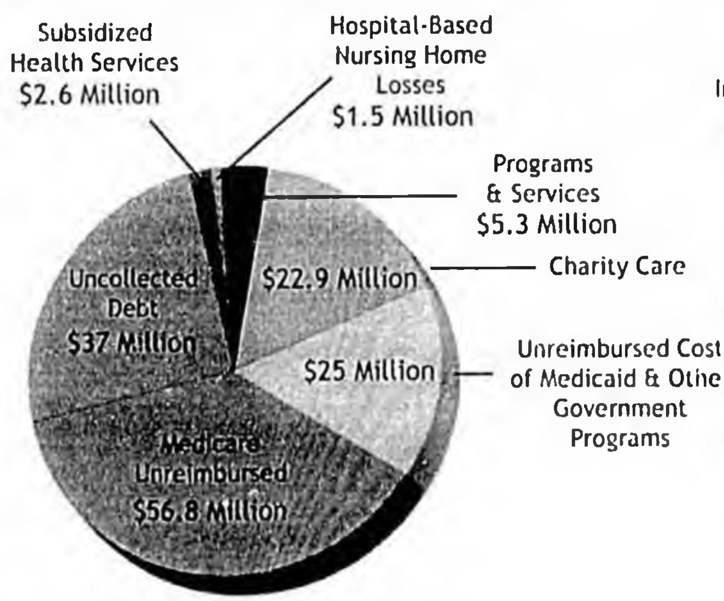
ASHNHA Community Benefits Survey Report Summary

Benefit Category	*Participants Served*	*Loss/Cost*
Community Health Improvement Services		
Community Health Education	57,394	$1,340,996
Support Groups	128	$2,798
Self Help	242	$1,900
Nonbilled/Reduced-Fee Clinics	7,016	$142,434
Health Screening	989	$49,494
Immunization	800	$18,807
Counseling	424	$76,755
Family Support Services	15	$2,120
Free/Discounted Prescriptions/Supplies to Patients	473	$75,512
In-Home Services	307	$1,060
Meals/Nutrition Services	5,382	$212,469
Transportation Services	628	$38,314
All Other Health Care Support Services	75	$500
Community Health Improvement Services Total	**73,873**	**$1,963,159**
Financial and In-Kind Contributions	15,730	$1,214,786
Health Professions Education Contribution	1,247	$2,044,967
Health Research Contribution	0	0
Community Building Activities	16,046	$79,375
Community Benefit Operations	0	$3,700
TOTAL PARTICIPANTS IN COMMUNITY BENEFITS PROGRAMS		**106,896**
Charity Care At Cost		$22,967,322
Medicaid Underpayment		$12,545,792
Losses on Other Public Programs (Excludes Medicare and Medicaid)		$12,543,156
Bad Debt at Cost		$37,198,890
Medicare Unreimbursed		$56,830,190
Subsidized Health Services		$2,664,408
Hospital-Based Nursing Home Losses		$1,501,816
TOTAL COMMUNITY BENEFITS		**$151,557,561**

Community Benefits Improve the Health of Thousands of Alaskans

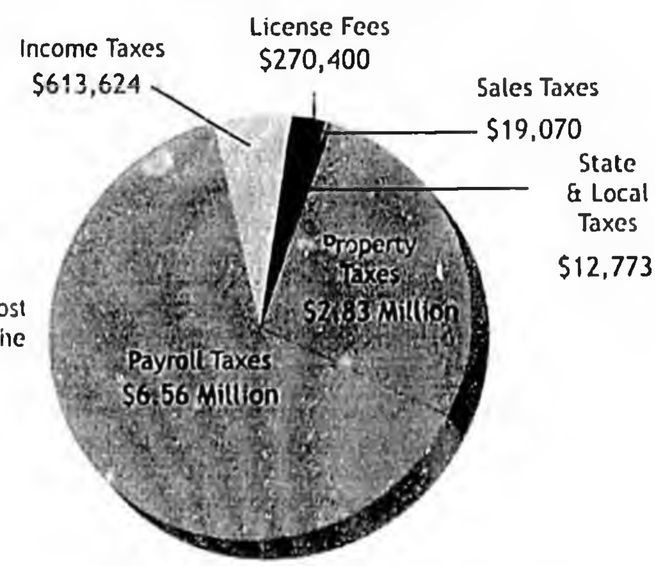
This report uses numbers to present the Community Benefits provided by Alaska hospitals. But Community Benefits are really about people. Community Benefits include care provided free of charge to Alaskans who are unable to pay. Programs and services can include prenatal care for expectant mothers and families, smoking cessation, preventing sports and other avoidable injuries, CPR and first aid classes, AIDS education and awareness, school-based health services, help for elderly citizens, work-site based health promotion, fitness and exercise seminars, blood pressure screenings, cholesterol testing, mental health and depression screenings, diabetes counseling, adult and child immunizations, blood drives, nutrition and weight loss management, substance abuse counseling, prescription drugs, transportation services, child car safety seat classes, and so much more. The goal of Community Benefits is to improve the health of Alaska by improving the quality of life for Alaskans.

Alaska Hospitals Provide $151.6 Million in Community Benefits



Total Value of Benefits Provided to Alaskan Communities: $151.55 Million

Alaska Hospitals Send $10.3 Million in Taxes, Fees to State and Local Governments



Total Payments to State and Local Governments: $10.31 Million

ASHNHA

The Federal Trade Commission
&
Certificate of Need Regulation

An AHPA Critique

January 2005

American Health Planning Association

. . . putting it all together

Table of Contents

I. Overview

In July 2004, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) issued a joint report titled *Improving Health Care: A Dose of Competition*. Described as advisory in nature, ostensibly, it offers recommendations on how to "improve the balance between competition and regulation in health care."[1] The authors say they want "to inform consumers, businesses, *[and]* policy-makers on a range of issues affecting the cost, quality, and accessibility of health care."[2] Except for more effective enforcement of antitrust laws, which falls within the scope of the agencies' responsibilities, the report seeks to effect change by influencing the views and conduct of others, particularly national and State policymakers.

Eliminating certificate of need (CON) regulation is only one of several problematic arguments and recommendations presented. It is the only recommendation that has gained much public attention, but the issue is given only cursory, dismissive consideration in the report.[3] The overall thrust of the report is to encourage movement to a "consumer driven" health care system that relies on market forces to determine costs (prices), access, and quality. CON regulation and planning is seen as an obvious obstacle to this goal, but the report also cautions against:

- Over-reliance on health insurance;
- The system-distorting effects of Medicare and other "administered pricing" schemes;
- Economic cross-subsidies within the system;
- Government-imposed service mandates;
- Attempting to control prescription drug prices;
- Permitting collective bargains by physicians, and generally; and
- Any other action or process contemplated, in the pursuit of other (perhaps larger) social goals and interests that might limit competition or the full application of market forces.

Criticism of CON regulation in *Improving Health Care* is not surprising. Given the FTC *raison d'etre* of promoting free markets and unfettered competition, and its longstanding opposition to CON programs, little else could be expected. Nevertheless, the unsupported conclusion that CON programs "pose anticompetitive risks" and "risk entrenching oligopolists and eroding consumer welfare" is little more than doctrinaire posturing. Similarly, the recommendation that States with CON programs "reconsider whether these programs best serve their citizens' health care needs" is gratuitous. State legislatures do this regularly, often annually.

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[1] FTC-DOJ press release July 23, 2004, at <http://www.ftc.gov/opa/2004/07/heathcarerpt.htm>.

[2] *Ibid.*

[3] CON and related planning are treated briefly as "miscellaneous subjects" in Chapter 8, the last chapter of the report. Although there are occasional allusions to CON regulation elsewhere in the report, the question is discussed directly in fewer than 10 pages of the 350 plus page report. The cursory treatment of CON planning and regulation appears calculated: CON regulation is treated dismissively, almost as an afterthought, in the body of the report, but is elevated to prominence in the recommendations (number 2) offered "to improve competition in health care markets". ***Improving Health Care: A Dose of Competition.*** A Report by the Federal Trade Commission and the Department of Justice, July 2004. The full report is available at www.ftc.gov. See specifically Chapter 8 (pp. 1-6) and the Executive Summary (p.22), both of which discuss CON regulation directly.