

ALASKA LEGISLATURE COMMITTEE FILES 2007-2008 SHES 1248

a Map of the
2007 Relative Scope and Review Thresholds: CON Regulation by State
(a geographic illustration of the CON matrix)



revised September 17, 2007

Weighted Range of Services Reviewed (see left side of matrix)

| | | | |
|---|---|---|---|
|  no CON |  0-9.9 |  10.0-19.9 |  20.0-44.0 |
|---|---|---|---|

The CON Matrix of 2007 Relative Scope and Review Thresholds: CON Regulated Services by State

(summarized from 2007 information collected by email directly from Certificate of Need directors - also see related map depicting relative levels of regulation across the United States)

| Rank (no. of svcs & weight) | Categories | Acute Care | ALT/AMBUCARE | Amb Surg Ctr | Blind Care | Business Centers | Cardiac Cath | CT Scanners | Gamma Knives | Home Hlt | Hospice | ICF/MR | LTC Hospita | Lithotripsy | Long Term Care | Med Ctr/Bldg | Mobile Hl Tech | MRI Scans | Neonatal Care | Obstetric Svcs | Open Heart Svcs | Organ Transplant | PET Scans (incl CT) | Psychiatric Svcs | Rad Therapy | Rehabilitation | Renal Dialysis | Air Lvg/RG | Subacute | Substance Abuse | Swing Beds | Ultra sound | Other (Items not otherwise covered) | Total (no of svcs) | compiled by Thomas R. Piper Missouri CON Program Jefferson City, MO 573 751 6403 | | | |
|--------------------------------------|------------------|------------|--------------|--------------|------------|------------------|--------------|-------------|--------------|----------|---------|--------|-------------|-------------|----------------|--------------|----------------|-----------|---------------|----------------|-----------------|------------------|---------------------|------------------|-------------|----------------|----------------|------------|----------|-----------------|------------|-------------|---|--------------------------|--|-----------|-----------|-----|
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | www.request-con.com | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Reviewability Thresholds | | | |
| | | Capita | Mod Eqp | New Svc | Weight | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29.7 | Vermont | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 27 | 1,000,000 | 1,000,000 | 500,000 | 1.1 | |
| 28.4 | Georgia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 26 | 1,483,083 | 823,934 | any amt | 1.1 |
| 25.2 | West Virginia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 28 | 2,000,000 | 2,000,000 | any amt | 0.9 |
| 24.8 | Maine | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 24 | 2,666,198 | 1,333,099 | 112,800 | 1.0 |
| 22.5 | Connecticut | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 25 | 3,000,000 | 3,000,000 | any amt | 0.9 |
| 22.8 | South Carolina | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 22 | 2,000,000 | 600,000 | 1,000,000 | 1.0 |
| 20.8 | North Carolina | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 26 | 2,000,000 | 750,000 | 0 | 0.8 |
| 18.9 | Dist of Columbia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 27 | 2,500,000 | 1,500,000 | 600,000 | 0.7 |
| 18.4 | Tennessee | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 23 | 2,000,000 | 1,500,000 | any amt | 0.8 |
| 17.1 | Alaska | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 19 | 1,150,000 | 1,150,000 | 1,150,000 | 0.9 |
| 17.0 | Mississippi | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 17 | 2,000,000 | 1,500,000 | any amt | 1.0 |
| 16.8 | Kentucky | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 21 | 2,380,123 | 2,380,123 | n/a | 0.8 |
| 16.8 | Rhode Island | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20 | 2,000,000 | 1,000,000 | 750,000 | 0.8 |
| 15.4 | New York | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 26 | 3,000,000 | 3,000,000 | any amt | 0.6 |
| 15.4 | Hawaii | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 26 | 4,000,000 | 1,000,000 | any amt | 0.6 |
| 15.2 | Michigan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 19 | 2,817,500 | any amt | any amt | 0.8 |
| 12.8 | New Hampshire | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 12 | 2,504,754 | 400,000 | any amt | 1.0 |
| 12.0 | Iowa | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 15 | 1,500,000 | 1,500,000 | 500,000 | 1.0 |
| 14.4 | Alabama | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 24 | 4,251,780 | 2,125,890 | any amt | 0.6 |
| 12.8 | Missouri | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 12 | 1,000,000 | 1,000,000 | 1,000,000 | 1.0 |
| 11.9 | Washington | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 17 | 1,000,000 | n/a | any amt | 0.7 |
| 11.7 | New Jersey | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 13 | 2,000,000 | 2,000,000 | any amt | 0.9 |
| 8.4 | Arkansas | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 7 | 500,000 | n/a | n/a | 1.2 |
| 7.8 | Oklahoma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 6 | 500,000 | n/a | any beds | 1.3 |
| 7.2 | Delaware | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 12 | 5,800,000 | 5,800,000 | n/a | 0.6 |
| 6.3 | Virginia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 21 | 15,000,000 | 1st eqpt | 1st svcs | 0.3 |
| 6.3 | Montana | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 7 | 1,500,000 | n/a | 150,000 | 0.9 |
| 5.7 | Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 19 | 10,000,000 | n/a | 5,000,000 | 0.3 |
| 5.6 | Florida | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 8 | n/a | n/a | n/a | 0.7 |
| 5.1 | Massachusetts | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 17 | 13,592,292 | 1,449,844 | any amt | 0.3 |
| 4.8 | Illinois | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 16 | 7,818,549 | 6,809,655 | any amt | 0.3 |
| 4.5 | Nevada | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 9 | 2,000,000 | n/a | n/a | 0.5 |
| 4.4 | Wisconsin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4 | 1,000,000 | 600,000 | any LTC | 1.1 |
| 2.4 | Oregon | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | any LTC/hsp | n/a | LTC/hsp | 1.2 |
| 1.8 | Ohio | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | 2,000,000 | n/a | n/a | 0.5 |
| 0.4 | Nebraska | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | any LTC/rehab | n/a | n/a | 0.2 |
| 0.4 | Louisiana | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | n/a | n/a | LTC/MR | 0.2 |

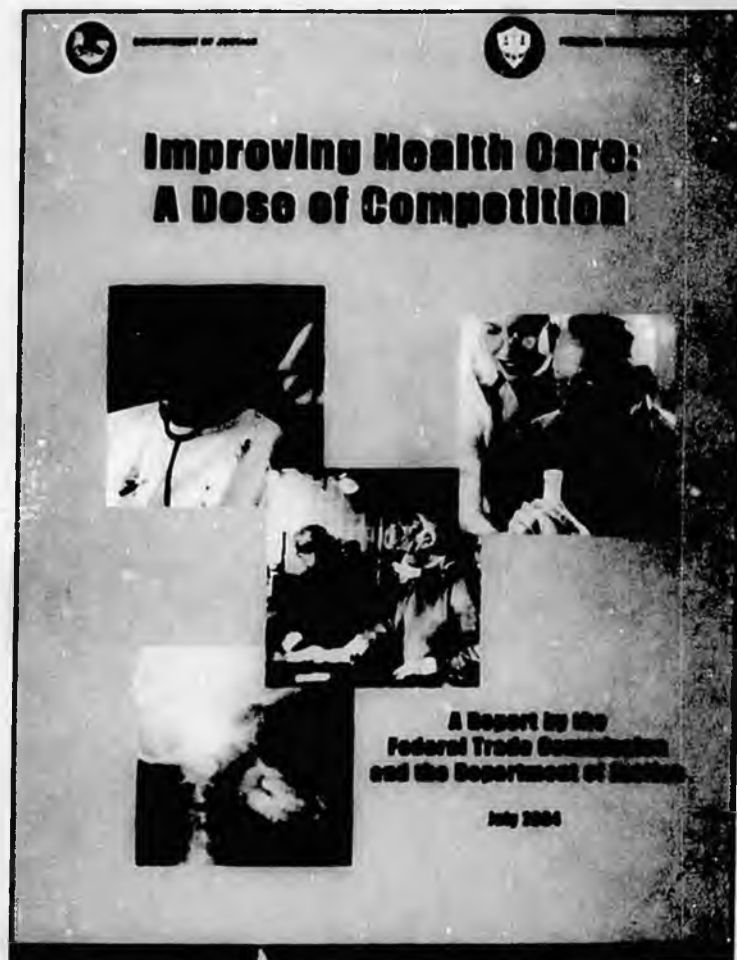
broadly defined regulation

Rank of item: Rank order relative to values of items reviewed. NOW intensity of analysis or conclusions which are based on Criteria and Standards and decisions

Source: Updated September 17, 2007 using most recent information available

July 2004 FTC/DOJ Report & AHPA Critique

Improving Health Care: A Dose of Competition




The Federal Trade Commission
&
Certificate of Need Regulation

An AHPA Critique

January 2005

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 American Health Planning Association
... putting it all together

QuickTime™ and a
TIFF (Uncompressed) decompressor
are needed to see this picture.

July 2004 FTC/DOJ Report

Intent of the Message

Recommendation 2. States should decrease barriers to entry into provider markets.

a) States with Certificate of Need programs should reconsider whether these programs best serve their citizens' health care needs.

The Agencies (*FTC and DOJ*) 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. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market. As noted earlier, the vast majority of single-specialty hospitals – a new form of competition that may benefit consumers – have opened in states that do not have CON programs. Indeed, there is considerable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns.

b) States should consider adopting the recommendation of the Institute of Medicine to broaden the membership of state licensure boards.

c) States should consider implementing uniform licensing standards or reciprocity compacts to reduce barriers to telemedicine and competition from out-of-state providers who wish to move in-state.

www.ftc.gov/opa/2004/07/healthcarerpt.htm

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are needed to see this picture.

July 2004 FTC/DOJ Report

Objective Conclusions

The stated FTC goals of market efficiency, consumer control and informed stakeholders have been **integral to community-based health planning** for more than 40 years. The community has always been, and remains, an integral part of the planning, development and regulatory processes.

The principal difference between FTC beliefs and assumptions, and those favoring planning and targeted regulation is **how best to manage the tension between public and private interests, and between short-term and long-term perspectives and incentives.**

We believe in the importance of community-oriented health services and systems, and **encourage ongoing reassessment of health planning and CON regulation** to ensure they remain responsive to technological change, evolving health care practices, and community values and needs.



Marketplace Issues Revealed

- **Capital costs** in healthcare are passed on to the consumers.
- **Competition** in healthcare usually **does not lead to lower charges**:
 - ... providers control supply
 - ... demand is determined by providers
 - ... consumers lack adequate information.
- **Consumers do not** (and usually cannot) **“shop”** for health care, at least, not based on price or quality (usually unavailable).
- **Increased capacity costs** lead to higher delivery charges.
- **Consumers do not pay most of the cost**, and do not really know the true cost of, or charges for, most care (third-party payers do).
- **Providers have few direct incentives** to lower charges/utilization.



CON Concepts Views of the Critics

- CON focuses mostly on **cost control** by restricting market entry, capital outlays and technical innovation.
- CON looks largely at the **geographic aspects** of access rather than broader social and system access questions.
- CON does not assume a role in, or have a concern with, **quality** in health services.
- CON is generally unaware of the uses and limits of **market forces** in health services delivery.

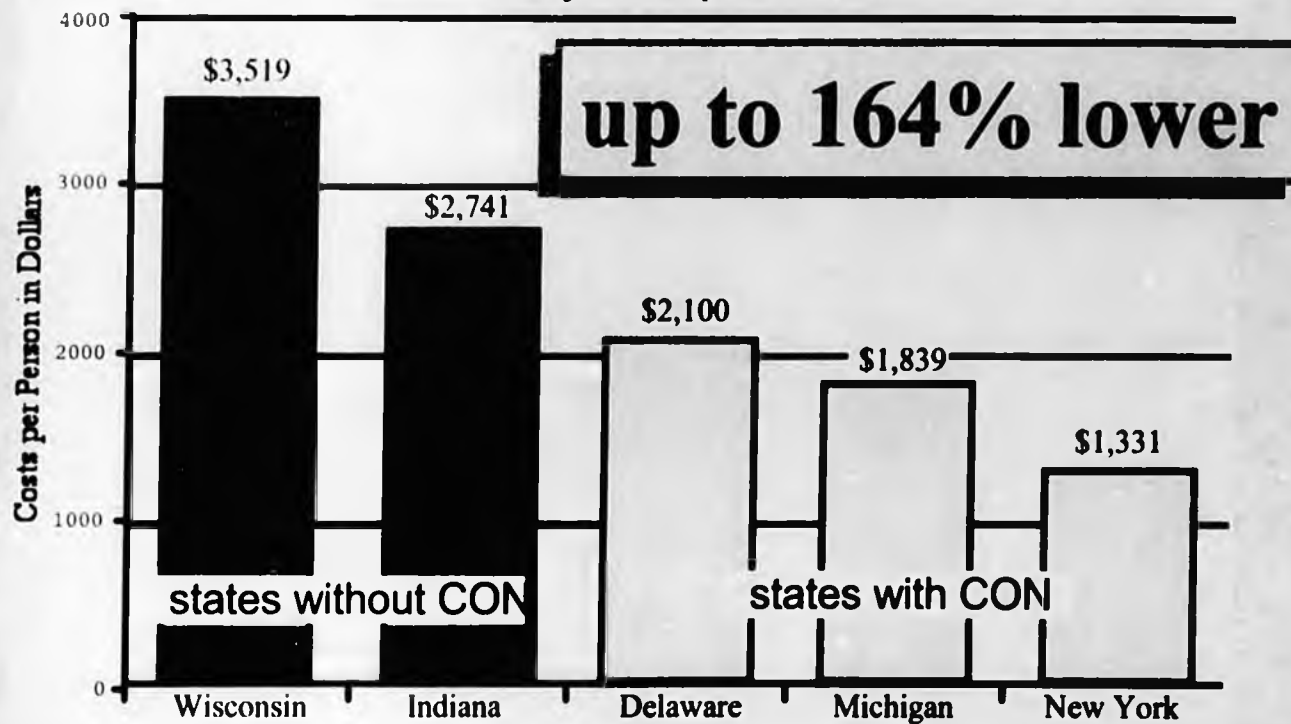


CON: Unique Planning and Regulatory Tool

- **Planning-based**, analytically-oriented, fact-driven
- **Open process**, with provision for direct public involvement
- **Structured to compensate** for market deficiencies & limitations and foster market efficiency
- **Designed to highlight and accentuate quality** unlike licensure and certification with their leveling effects
- **Promotes economic and quality competition** within the context of health care market realities
- **Practical and educational** rather than ideological
- **Doorway to excellence** rather than barrier to market entry

Big-Three Automakers Health Care Costs non-CON vs. CON states

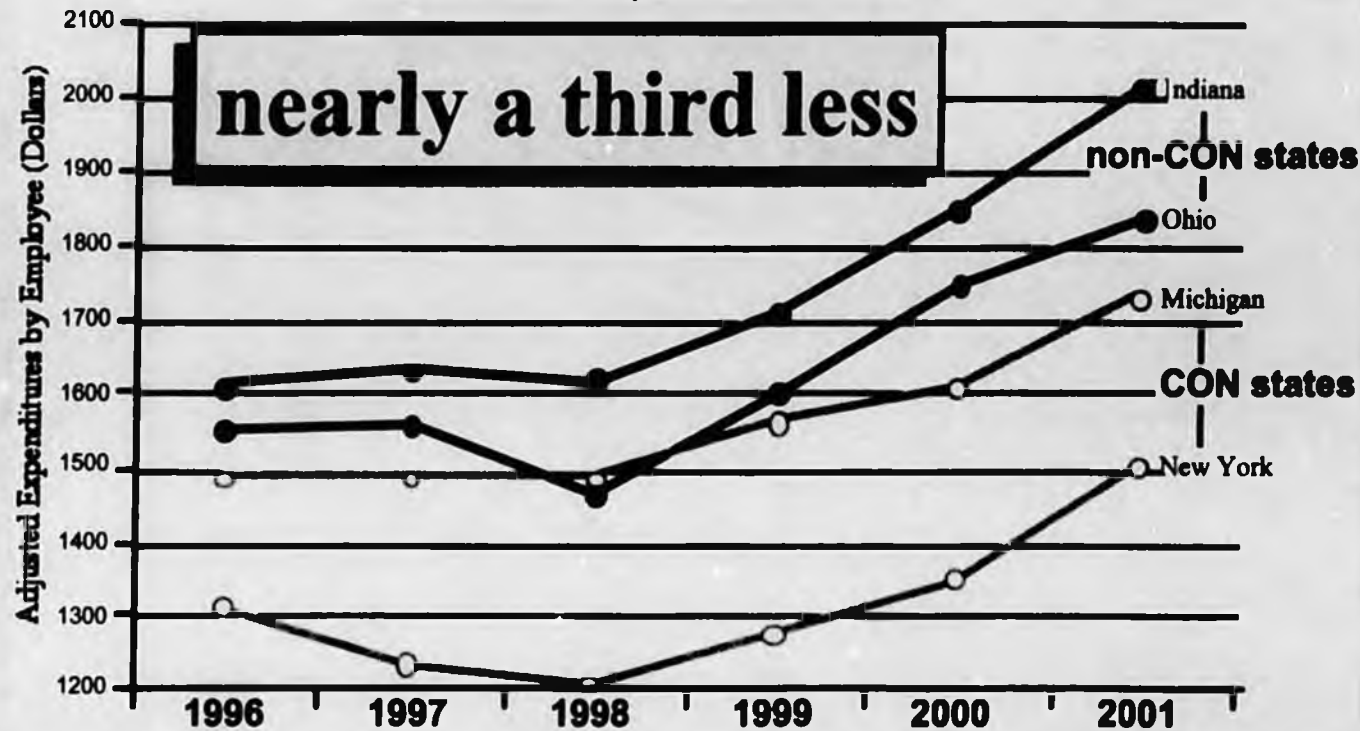
Adjusted Health Care Cost Per Person
By Location and State CON Status
DaimlerChrysler Corporation, 2010



CON states have lower health care costs than non-CON states!

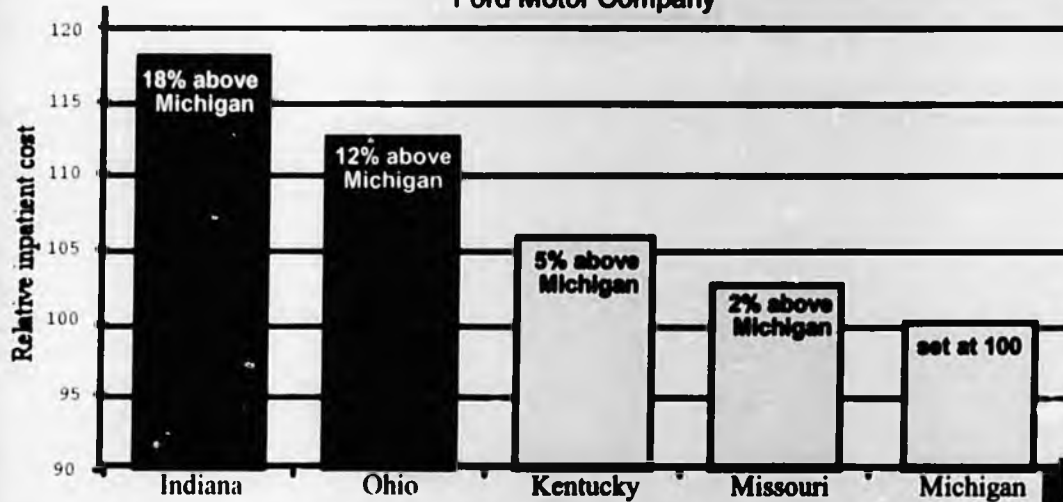
Big-Three Automakers Health Care Costs non-CON vs. CON states

Adjusted Health Care Expenditures Per Employee
By State and CON Regulation Status
General Motors Corporation, 1996-2001

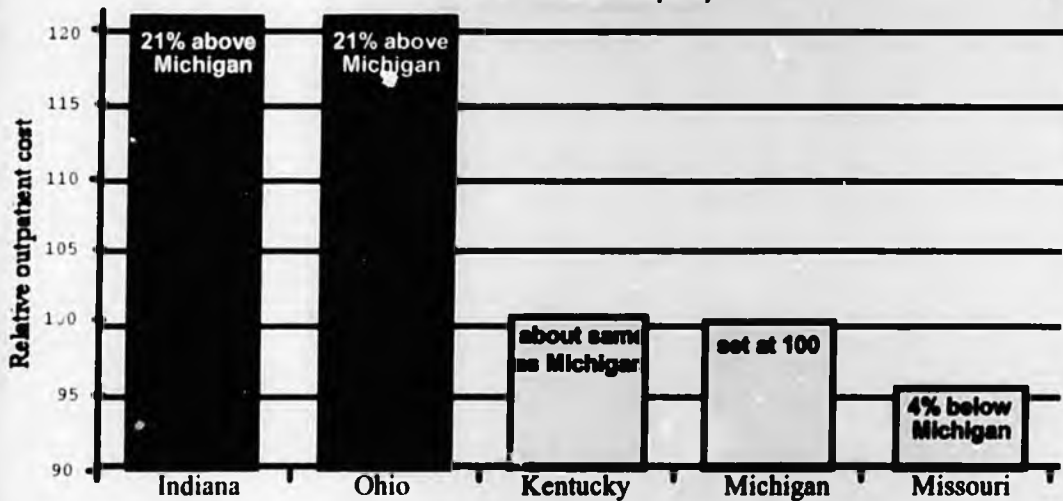


CON states have lower health care costs than non-CON states!

Hospital Inpatient Relative Cost
 (per 1000 members normalized to Michigan Year 2000 = 100)
 Ford Motor Company



Hospital Outpatient Relative Cost
 (per 1000 members normalized to Michigan Year 2000 = 100)
 Ford Motor Company



**Big-Three
 Automakers
 Health Care
 Costs
 non-CON vs.
 CON states**

about 20% less

**CON
 states
 have
 lower health
 care costs
 than
 non-CON
 states!**

Consequences of Unrestricted Health Care Competition if SB 245 is approved

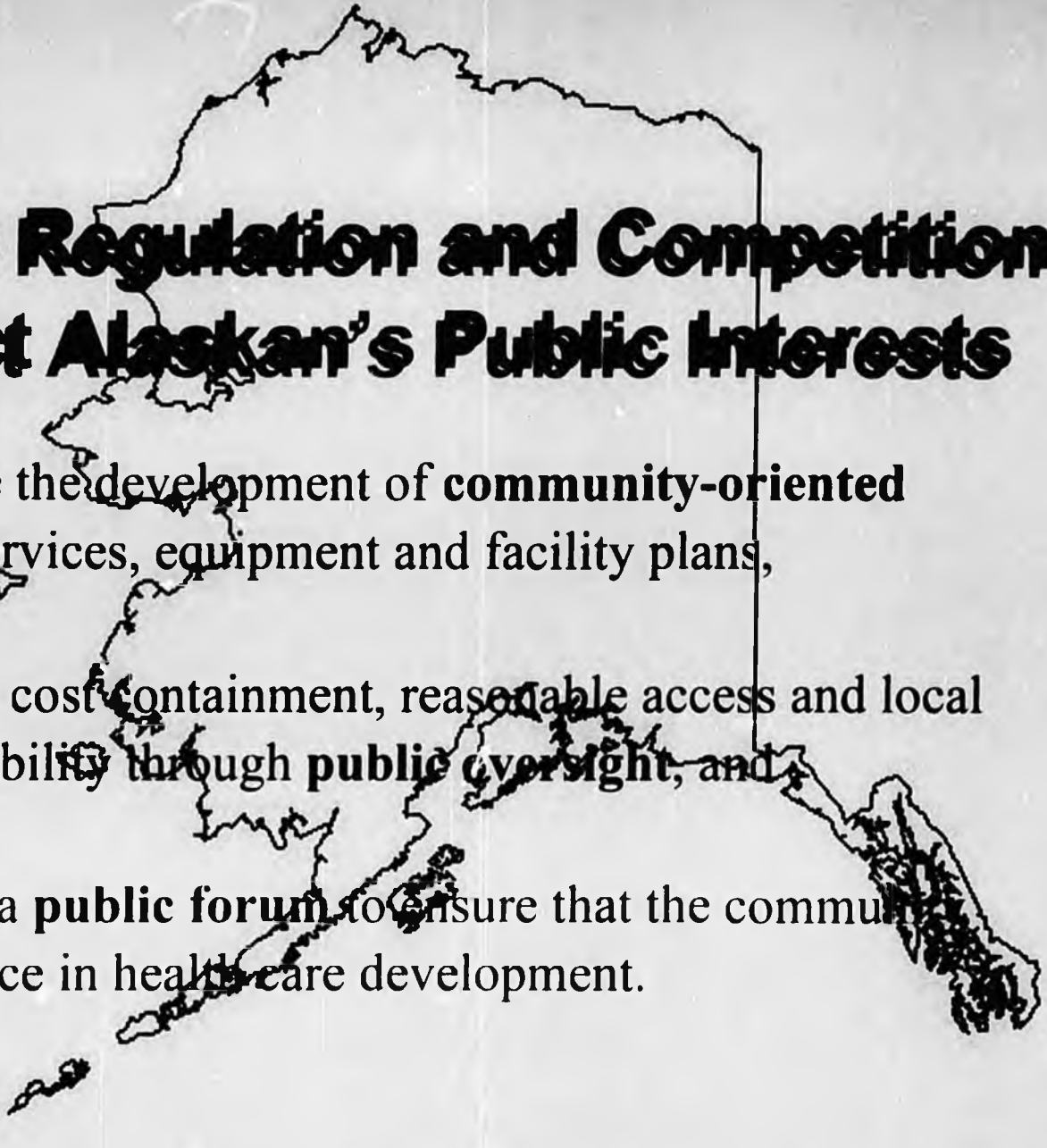


- **Splinters the provider delivery network**
- **Threatens “safety net facilities”**
- **Creates high-profit niche markets**
- **Supply drives demand!**



Alaska Needs Health Care Public Oversight

- **Prices** for health care services are going up almost **8%** annually, compared to less than **2.6%** inflation for most other services.
- Health care **spending** divides out to **\$12,106** per family, which is **16%** of the gross domestic product . . . this spending is projected to reach **20%** by 2015 if current levels continue.
- Employer insurance **premiums** increased by **6.1%**, which threatens the ability of business to effectively compete in the domestic and world markets.
- High cost of health care is dipping into **retirement reserves** with average cost of nursing home care over **\$60,000** per year.

An outline map of the state of Alaska is positioned in the background, centered behind the text. The map shows the state's irregular coastline, including the Aleutian Islands to the west, the main body of the state, and the Alaska Peninsula to the south.

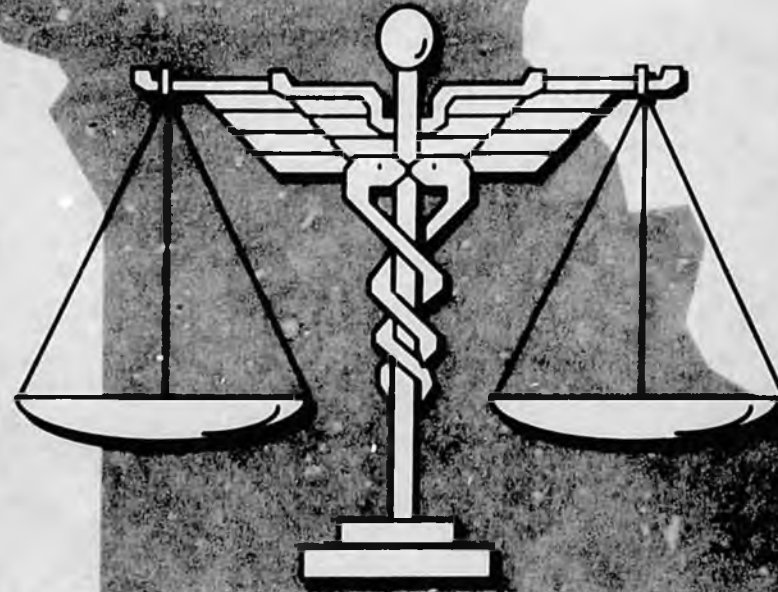
Balance Regulation and Competition: Protect Alaskan's Public Interests

- Promote the development of **community-oriented** health services, equipment and facility plans,
- Achieve cost containment, reasonable access and local accountability through **public oversight**, and
- Provide a **public forum** to ensure that the community has a voice in health care development.

Certificate of Need: Protecting Public Interests



*Missouri CON . . . promoting responsive planning,
evaluating health systems and reducing unnecessary health costs*



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Certificate of Need: Protecting Public Interests



Position on Senate Bill 245 - February 8, 2008

Prepared by: Rod Betit, President/CEO

Madam Chairman, members of the Committee, I would like to speak to all three parts of the bill before you today, specifically the provisions repealing certain parts of CON law, creation of a Health Care Commission, and imposing mandatory information reporting requirements.

First, let me give a quick overview on ASHNHA's position on each section of SB 245 followed by a sectional analysis.

ASHNHA's POSITION ON SECTIONS CONTAINED IN SB 245 (Version A):

- | | |
|--|---------------------------|
| ▪ Section 1 - Statewide Health Plan: | SUPPORT AS IS |
| ▪ Section 2 - Establish Alaska Health Care Commission | SUPPORT IF AMENDED |
| ▪ Section 2- Establish Health Care Information Office & Establish Mandatory Reporting Requirement | SUPPORT IF AMENDED |
| ▪ Section 3- Repeal CON authority | OPPOSE |
| ▪ Section 4 - More CON Repeal Provisions | OPPOSE |
| ▪ Section 5 - More Alaska Health Care Commission | SUPPORT AS IS |
| ▪ Section 6 - More CON Repeal Provisions | OPPOSE |
| ▪ Section 7 - More CON Repeal Provisions | OPPOSE |
| ▪ Section 8 - More CON Repeal Provisions | OPPOSE |
| ▪ Section 9- More CON Repeal Provisions | OPPOSE |
| ▪ Section 10 - CON Repeal Effective Dates | OPPOSE |
| ▪ Section 11 - Statewide Health Plan Effective Date | SUPPORT AS IS |
| ▪ Section 11 - Health Care Commission Effective Date | SUPPORT AS IS |
| ▪ Section 11 - Health Care Information Office Effective Date | SUPPORT AS IS |
| ▪ Section 11 - Mandatory Reporting Effective Date | OPPOSE |

Section 1 - Statewide Health Plan:

ASHNHA supports the recommendation by the Governor's Health Care Strategies Planning Council to develop a statewide health plan. Development of a plan would serve several important purposes. One of those would be to plan for the appropriate development of health care infrastructure and equipment to meet Alaskan's health care needs both in the near and long term. Absence of such a plan has contributed to the ongoing disagreement as to both the quantity of unmet health needs in the State, and the most appropriate setting in which to meet those needs community by community. Initial development of a statewide health plan will likely take several years to complete but could be kept current and relevant with minimal effort and cost.

Amendments recommended in Statewide Health Plan Section 1:

(a) None. ASHNHA supports this section as written.

ASHNHA
Alaska State Hospital and Nursing Home Association

Section 2 - Establish Alaska Health Care Commission:

ASHNHA members support the creation of a Commission to develop incremental strategies to provide affordable, quality health care choices for all Alaskans, to oversee development of the State's health care data information base, and to promote individuals taking responsibility to improve their overall health status. While ASHNHA supports the establishment of a Commission, SB 245 does not reflect the diverse membership needed to assure broad based support of Commission recommendations.

Amendments recommended in Health Care Commission Section 2:

(a) ASHNHA recommends the membership be modified to reduce the number of Administration representatives on the Commission, while increasing the number of consumers, business and health care industry representative on the Commission.

(b) Recommend balancing the member selection process in some way. Selection of the members should have support by the Governor and the Legislature.

There are several approaches to modifying the membership and appointment components of SB 245 that would be acceptable to ASHNHA members, and we commit to meet immediately with the Administration, the Legislature and other interested parties to come up with a suitable solution to this important component of the bill.

Section 2 - Establish Health Care Information Office & Mandatory Reporting Requirement:

ASHNHA supports the goal of providing accurate and current health care information for consumers to assist them in making health care decisions. ASHNHA's members have been voluntarily expanding reporting of health care cost, quality and charity care information for many years. All of that information is already available to the Department.

Until now the State has shown no interest in creating a consumer friendly resource containing this type of health care information. Further there was no discussion with ASHNHA or other health care providers about how to best approach this goal prior to introduction of this legislation. This is a complicated and involved process that will take years to fully develop and implement. Some progress could be made by the State in the short term using the data already being provided by hospitals but certainly not by July 1, 2008.

While ASHNHA's members support the goal of expanding health care cost and quality information for consumers, there has been little thought given to how this will actually be accomplished. The bill is unclear on critical details with which to answer the following four questions:

1. **Who must report this data?** AS 47.32 (page 8, line 4) lists the following:
 - ambulatory surgical centers;
 - assisted living homes;
 - child care facilities;
 - child placement agencies;

Position on Senate Bill 245 - February 8, 2008

Prepared by: Rod Betit, President/CEO

- foster homes;
- free-standing birth centers;
- home health agencies;
- hospices, or agencies providing hospice services
- hospitals;
- intermediate care facilities for the mentally retarded;
- maternity homes;
- nursing facilities;
- residential child care facilities;
- residential psychiatric treatment centers;
- rural health clinics;
- runaway shelters.
- Independent Diagnostic Testing Facilities come in on page 8, line 5

All of these entities would be expected to start reporting yet undefined data effective July 1, 2008. This is clearly not possible. Noticeably missing from the list is a key piece of the cost and quality equation for consumers, that of the physician. How can a consumer make a choice about their care without this information?

Also missing from this list is pharmacies yet the Department presented a State of Florida web site as an example of what the consumer would be able to access under their reporting program. How could that come about without statutory authority?

ASHNHA questions if all of these other 'facilities' understand whether they are to report under the provisions of SB 245 effective July 1, 2008.

2. What data must be reported and how does that compare to what is reported now?

It is not clear what data the department is looking for. ASHNHA is the only entity in the list of impacted facilities that currently reports data and we do that voluntarily. The list of reports available to the Department right now is quite extensive including:

- ASHNHA members report all hospital inpatient data related to patient stays. This includes diagnosis, all treatment provided, charges, reimbursement received, third party insurers, length of stay, sex of patient, age of patient, patient residence, and a host of other information.
- ASHNHA members voluntary expanded beyond the inpatient data base to the department this year by reporting data for all outpatient services provided and all emergency department services. This includes all outpatient surgery, lab and imaging services
- ASHNHA members report financial data on the operations of their facilities on an annual basis.
- ASHNHA members report data on key quality measures to the federal Department of Health & Human Services and to the American Hospital Association. These data are available to the public at these posted web sites for

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Prepared by: Rod Betit, President/CEO

comparing Alaska hospitals to each other as well as comparing Alaska hospitals to those in other states.

- Many ASHNHA members also voluntarily report quality information on a number of quality and patient safety measures that go beyond that reported to the federal government. This data is also publicly available.
- ASHNHA members have supported the Legislature's desire to add health care facility acquired infections to the list of reportable items as proposed in SB 68 that passed out of this committee last year. We believe this is important information to report but recognize it is a difficult area to be statistically reliable in. SB 68 creates a process over several years to look at what other states have done, design a reporting program suitable for Alaska, and then implement reporting in Alaska. It is wise to go slow here as 14 states have passed similar legislation but only 2 or 3 have actually begun reporting due to the challenges this reporting presents.
- For the first time ASHNHA's members have again voluntarily launched and funded a new report that will give you and all Alaskans a look at the total 'community benefits' Alaska's hospitals provide. I have attached a copy of this inaugural report. Please note our first effort at collecting this information accumulated \$150 million in benefits of one type or other. This number will grow in future years as we become more sophisticated at capturing this information.

3. How will the data be collected, validated and kept current?

There are several ways to develop and implement a reporting system. Three of those would be as follows for the hospital portion of this system. Which path is the State on?

- Hospitals could send the same raw data we send to these other expert data agencies and the department could edit, purge confidential information, format and post the data to their own data web site. This would be Herculean task essentially replicating efforts and costs already being invested; or
- The department could enter into an agreement with little or no cost to obtain the data from all the data agencies already producing reports and populate their own data site with that clean data. The department could then use that data to generate the online consumer inquiry system being envisioned; or
- The department site could provide links to these already existing data sites for ease of consumer movement through the system. This would be the simplest, least costly, and easiest to maintain approach because the cost, liability and administrative burden to keep the data current and accurate rest with other expert data parties.

4. When can reporting of new data elements realistically begin?

Clearly, answers to the above questions need to be obtained to evaluate when any new mandatory reporting requirement can be realistically implemented. In ASHNHA's opinion the July 1, 2008 date is simply unrealistic. Further when you consider all the

Position on Senate Bill 245 - February 8, 2008

Prepared by: Rod Betit, President/CEO

other providers who will be expected to report that do not have the jump start that hospitals have by voluntarily reporting for many years, there is serious question about how thoroughly the scope and complexity of this proposal has been fleshed out.

Amendments recommended in mandatory health care data reporting Section 2:

(a) Recommend these provisions be rewritten in a permissive rather than prescriptive tone and the development/implementation responsibility be placed with the Health Care Commission.

(b) Recommend all parties who will be expected to report be clearly listed in this section of the bill. The parties listed should include pharmacies and physicians which are not now included.

(c) Recommend the timelines for implementation of reporting be extended beyond July 1, 2008. There simply is no way this timeline can be met.

(d) Recommend the department initiate its reporting efforts as it pertains to hospitals with the data already being provided that is not now being made available to consumers after a dialog with ASHNHA on how to best proceed.

Sections 3, 4, 6 7, 8, 9, and 10 - Repeal Certificate of Need:

ASHNHA's membership opposes these sections of SB 245. We do not believe repealing CON is good public health policy.

Alaska CON statutes were updated in 2004 to align CON review with rapidly evolving changes in health care delivery practices. These statutory changes have only recently been fully implemented (2006) after a lengthy regulatory adoption effort by the Department of Health & Social Services to fully define the criteria to be used for review of any CON application.

Yes differences of opinion continued to exist within the stakeholder community on how these new laws should be applied. To address this Commissioner Jackson appointed a committee of 21 individuals to meet face-to-face to iron out their differences in September 2007. As you already know, by an 89% vote the participants voted **not to repeal CON**.

As a member of the Rulemaking Committee I can report that we took this charge very seriously. I and other participants believe we did what was asked of us and produced a series of recommendations for improving CON policy and process that the Department should consider or ask us to go back and work on further.

ASHNHA members believe the repeal proposed by SB 245 would invite uncontrolled growth of health care services. This would have serious consequences to the financial viability of existing health care providers and undermine their ability to provide needed medical services to their community. In addition we believe it will cause health care costs to increase more rapidly rather than less rapidly.

Position on Senate Bill 245 - February 8, 2008

Prepared by: Rod Betit, President/CEO

Decisions around CON should be made in concert with other strategies the State should consider to make the health care market a more balanced economic environment for hospitals. You have heard these arguments before so I will not repeat them here. I have attached the key arguments ASHNHA has made over the years as to why CON is an important health policy tool.

Recently you heard testimony from the Department of Justice about their opinion on whether CON process is helpful or not to the consumer. I have attached a policy paper from the American Health Planning Association that gives a critique of the Department of Justice paper for your additional consideration.

Amendments recommended in CON sections of bill (3, 4, 6, 7, 8, 9, 10):

(a) ASHNHA's members recommend that all CON sections be deleted from SB 245 and the Department asked to continue working with the Rulemaking Committee to refine CON regulations and processes to resolve any continuing concerns.

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

ASHNHA

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.



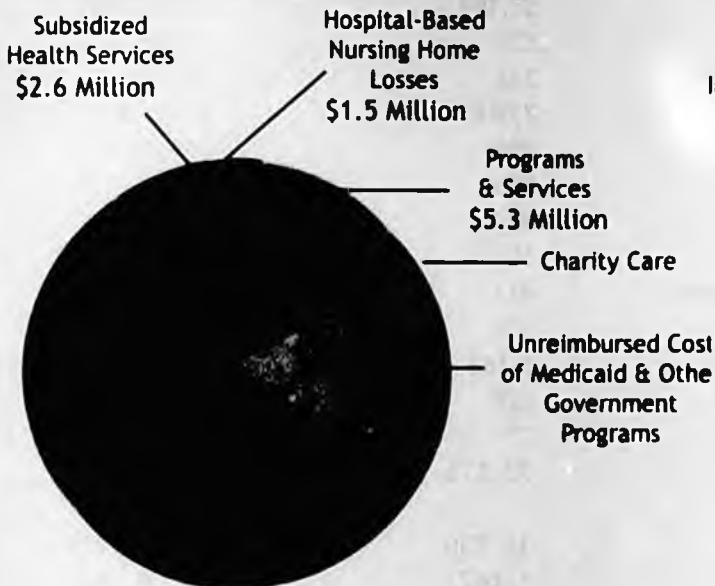
ASHNHA Community Benefits Survey Report Summary

| <u>Benefit Category</u> | <u>Participants Served</u> | <u>Loss/Cost</u> |
|--|----------------------------|----------------------|
| 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

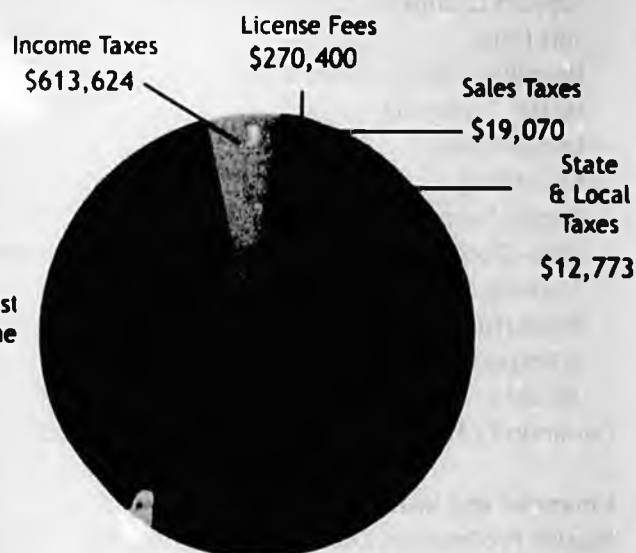
This report uses numbers to present the Community Benefits provided by Alaska hospitals. But Community Benefits are really about people. Community Benefits include care provided free of charge to Alaskans who are unable to pay. Programs and services can include prenatal care for expectant mothers and 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



Alaska State Hospital and Nursing Home Association
 426 Main Street • Juneau, Alaska 99801
 907-586-1790 • www.ashnha.org

**The Federal Trade Commission
&
Certificate of Need Regulation**

An AHPA Critique

January 2005



American Health Planning Association
... putting it all together

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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’être* 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.

¹ FTC-DOJ press release July 23, 2004, at <<http://www.ftc.gov/opa/2004/07/healthcarerpt.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.

II. Context & History

Improving Health Care is but the most recent, and perhaps the most visible, example of the decades-long FTC effort to shape the climate of opinion on health care.⁴ In a February 9, 1987, letter to the Health Systems Agency of New York City, advising the agency to not try to reduce excess hospital bed capacity in the city, Jeffrey Zuckerman, Director of the FTC's Bureau of Competition, noted that the FTC had "been engaged in extensive efforts to preserve and promote competition in health care markets" for more than a decade.⁵ A year earlier, Terry Calvani, FTC Acting Chairman, had made it clear that CON was a part of that effort:

"A major initiative for the coming year . . . will be a program to halt actions by health-care providers which are designed to raise the costs and deter the entry of competitors. For example, state law frequently requires a hospital to obtain a "certificate of need" (CON) before it can build a new facility. The Commission has discovered that existing hospitals have sometimes opposed these CON applications, not in good faith, but merely to delay the entry of a new competitor and to burden it with heavy costs. The Commission will watch for such activities and will challenge them as trade restraints where appropriate."⁶

In other words, certificate of need (CON) regulation has long been anathema to the FTC. The Commission has actively opposed CON programs for at least the last two decades.

It is unclear how the FTC ascertained the motivation and intent of hospitals participating in CON review processes, but its attack on CON has not been limited to, or even meaningfully related to, preventing existing service providers from engaging in restraint of trade. Beginning in the mid-1980s, Commission staff regularly urged State policymakers and health care officials to eliminate or, alternatively, limit CON regulation. The period between 1986 and 1989 was particularly intense. Beyond its sustained generic opposition, during this period alone the FTC formally

⁴ Apparently, the Commission had no great concern about the structure and nature of the health care system before the advent the Medicare program and the economic and system changes dating from that period. There is little, if any, evidence of FTC concern about the structure and operational aspects of the health care system as long as its was dominated by market forces, i.e., before Medicare and other government-sponsored health and health-related programs.

⁵ Jeffrey Zuckerman, Director, Bureau of Competition, U.S. Federal Trade Commission, to Giri Vuppala, Assistant Director, Planning and Implementation, Health Systems Agency of New York City, February 9, 1987, p. 2.

⁶ See FTC press release, February 21, 1986 at www.ftc.gov. See also FTC annual reports for 1986 and 1987. U.S. Federal Trade Commission, Washington, D.C.

opposed CON regulation in Georgia⁷, Hawaii⁸, Maryland⁹, Michigan¹⁰, Nebraska¹¹, New York¹², North Carolina¹³, Ohio¹⁴, Pennsylvania¹⁵, and Virginia.¹⁶

FTC attacks have been multifaceted, with arguments ranging from the purported failure of CON regulation to meet legislative cost control objectives to assertions that it results in higher operating costs and charges, threatens quality, reduces innovation and system efficiency, and

⁷ In March 1988, FTC staff said "We believe the continued existence of CON regulation is contrary to the interests of health care consumers in Georgia. . . . More importantly, CON regulation tends to foster higher prices, lower quality and reduced innovation in health care markets". See FTC press release, March 7, 1988, at www.ftc.gov.

⁸ In early 1987, FTC staff told Hawaii legislators "we strongly encourage repeal of CON legislation. There is no evidence that the CON regulatory process has served its intended purpose of controlling health care costs. Indeed, CON regulation may well increase prices to consumers by restricting supply of hospital services below the level that would exist in a non regulated competitive environment." See FTC press release, March 17, 1987, at www.ftc.gov.

⁹ In 1987, FTC staff advised Maryland policymakers to not control ambulatory surgery center development under the State's CON program. See FTC Annual Report, 1987, U. S. Federal Trade Commission, Washington, D.C. at www.ftc.gov.

¹⁰ In March 1988, FTC staff advised Michigan health officials that the State's CON regulations were (are) "contrary to the interests of health care consumers in Michigan" because they "tend to decrease efficiency and impede competition." The staff also asserted "any potential benefits of CON regulation are likely to be outweighed by its adverse effects on competition in health care markets." See FTC press release, May 9, 1988, at www.ftc.gov.

¹¹ In February 1989, FTC staff informed the Nebraska Legislature "continuing CON regulation is likely to harm consumers by increasing the price and decreasing the quality of health services." See FTC press release, February 24, 1989, at www.ftc.gov.

¹² In February 1987, FTC staff advised New York City Health Systems Agency officials that a contemplated reduction in excess hospital capacity "would substantially reduce the incentives for hospitals in New York City to improve the price and quality of their services." Consequently, officials should "rely on the hospitals themselves, rather than government regulation, to determine appropriate capacity levels." See FTC press release, February 10, 1987, at www.ftc.gov.

¹³ In March 1989, FTC staff told the North Carolina policy-makers "CON regulation does not appear to be an efficient way to ensure the quality of health care services, to assure that health care is available to the indigent, or to control Medicaid expenditures for nursing home beds." Staff also argued "consumers would most likely be better served if CON regulations were removed." See FTC press release, March 14, 1989, at www.ftc.gov.

¹⁴ In June 1989, FTC staff told the Ohio State Senate "'there is near universal agreement' among health care economists that Certificate of Need regulation 'has been unsuccessful in containing health care costs.'" See FTC press release June 22, 1989, at www.ftc.gov.

¹⁵ In April 1988, FTC staff urged Pennsylvania to eliminate CON regulation, arguing "the benefits of CON regulation, if any, are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, continuing CON regulation is likely to harm consumers by increasing the price and decreasing the quality of health services in the state." See FTC press release, April 1, 1988, at www.ftc.gov.

¹⁶ In August 1987, FTC staff advised Virginia officials to eliminate its CON regulation of health care facilities because such regulation is "contrary to the interests of health care consumers" and "market forces generally allocate society's resources far better than decisions of government planners." FTC staff also asserted "any potential benefits of CON regulation are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, CON regulation is likely to harm consumers on balance by increasing the price, and decreasing the quality, of health services in Virginia." See FTC press release, August 10, 1987, at www.ftc.gov.

limits access to care. Whatever the focus of the argument presented in individual states, the underlying FTC argument in all cases was, and remains, that in health care—as in other sectors of the economy—an unregulated market is superior to planning and regulation in assuring quality, access and cost-effectiveness. In addition to consistently opposing CON regulation for at least the last 20 years, the FTC has also opposed related state planning and regulatory initiatives.¹⁷

Fourteen states have dropped their CON programs since the mid-1980s. It is not clear how many of these states, if any, responded to FTC arguments or recommendations. Commission staff was active in a number of them, responding to the inquiries of CON opponents, advising state lawmakers to oppose or otherwise limit CON regulation, and preaching the redeeming value of market forces in health care. FTC officials have devoted substantial effort to opposing CON regulation and appear to believe their campaign was necessary, if not uniformly successful. After a brief hiatus, they now appear ready to resume the crusade.

Ostensibly, *Improving Health Care* was issued as an “educational resource” to States and other interested parties. It is unclear how State policymakers will respond to the current FTC advice. Those engaged in the day-to-day struggle to make health care available and affordable, or at least nominally accessible, to all in need necessarily have proven resistant to the siren song of free markets and unfettered competition as *the* solution to cost, quality and access problems. Nevertheless, the 2004 report will certainly encourage opponents of CON, whatever their motivation.¹⁸ There is likely to be much discussion in State legislatures during upcoming legislative sessions. CON regulation is likely to remain in the FTC crosshairs as long as a significant number of States have such programs.

III. Nature of the FTC Critique

Stated simply, the FTC argument against CON regulation holds that health care is as much subject to orthodox economic principles and doctrine as any other sector of the economy. Consequently, the best (i.e., the surest, most effective, most efficient) way to assure quality, efficiency, access, innovation, and lower prices is to rely on market forces and competition. The Commission recognizes that many do not view health care as a commodity that is, or should be, responsive to market forces. The authors lament that much of the public, nationally and internationally, view health care as “a special good” that is “not subject to normal market forces, with significant obligational norms to provide necessary care without regard to ability to pay.”

¹⁷ The FTC opposed the enactment of “certificate of public advantage” legislation in a number of states in the 1990s. These legislative initiatives attempted to provide guidance and “safe harbors” for certain cooperative arrangements that appeared warranted, especially following the sharp nationwide reduction in inpatient hospital use during the previous decade, to promote efficiency and the financial viability of some services. On March 10, 1993, FTC staff advised North Dakota officials that such legislation “could raise costs and reduce quality”. See FTC press release, March 10, 1993 at www.ftc.gov. Similar advice was presented to Vermont officials on October 20, 1994. See FTC press release, October 20, 1994 at www.ftc.gov.

¹⁸ See, for example, the Virginia Department of Planning and Budget’s *Economic Impact Analysis* of proposed revisions to Virginia’s Certificate of Public Need State Medical Facilities Plan. The “analysis” is a gratuitous attack on certificate of need regulation, clearly modeled after the FTC argument and assumptions. Copies of the Virginia report are available from the Health Systems Agency of Northern Virginia, Falls Church, VA.

An underlying objective of the report is to change views on this question, especially among policymakers. The authors recognize that mediating forces (insurance, public health and payer programs, lack of accurate and reliable cost and quality information, and the absence of a truly independent and sovereign consumer) make the current health care market an imperfect one. They insist that, given this circumstance, all efforts should be directed at perfecting the market, and paying directly any additional cost that a free unfettered market may entail.

FTC arguments presented in opposition to CON regulation, and in support of unrestrained market forces, are necessarily largely doctrinaire. There is little analytical or factual basis for the criticism of CON or for the recommendation to eliminate it. Similarly, other than recitation of orthodox economic doctrine, little is presented to demonstrate that market forces have had, or are likely to have, the positive effects in the health care system that the authors claim or assume.

The FTC opposes most barriers to market entry, whatever their nature, purpose or function, as an article of faith. The report makes clear that the FTC opposition is grounded in orthodox economic doctrine and the principles of the "American" market system. The Executive Summary of the report concludes with the report anthem:

"The fundamental premise of the American free-market system is that consumer welfare is maximized by open competition and consumer sovereignty – even when complex products and services such as health care are involved. . . . The Agencies do not have a pre-existing preference for any particular model for the financing and delivery of health care. Such matters are best left to the impersonal workings of the marketplace." *Improving Health Care: A Dose of Competition, Executive Summary*, p. 11.

In other words, the FTC is not in favor of a particular model as long as the *de facto* model is the "American free market" model. Doctrine, or perhaps faith and hope, trump experience and reason. This is not surprising, given the FTC's mission of promoting competition. This inherent bias, though understandable, does not absolve the Commission of its responsibility to avoid substituting belief for fact, or to refrain from accepting uncorroborated allegations of interested parties as fact. The report, and the record compiled in producing it, shows the Commission relied on belief and uncorroborated allegations rather than demonstrated fact in its rebuke of CON.

Although packaged and presented as a major new report, the evidence and argument against CON regulation is either a rehash of FTC arguments from the 1980s,¹⁹ or the uncorroborated self-serving allegations of interested parties.²⁰ There is a notable absence of documented fact or cogent analysis. No new evidence is offered to support the claim that, by raising market entry barriers for some services, CON raises costs, impedes access, or threatens quality. References to

¹⁹ See Keith B. Anderson and David I. Kass, *Certificate of Need Regulation of Entry into Home Health Care*, FTC staff report, January 1986; Monica Noether, *Competition Among Hospitals*, FTC staff report, May 1987; and Daniel Sherman, *The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis*, FTC staff report, January 1988.

²⁰ See unsupported and anecdotal testimony of John Hennessy, Executive Director, Kansas City Cancer Centers (a subsidiary of U. S. Oncology) and Megan Price, Director, Contracts and Communications, Professional Nurses Association. Both were (are) disappointed CON applicants who made bold, uncorroborated assertions that are problematic on their face.

recent empirical evidence of the value of regional planning and CON regulation in helping control costs and maintaining quality are dismissed by citing the anecdotal comments of CON opponents.²¹

To the extent the FTC argument against CON is grounded in analysis, it is based largely on three FTC staff reports produced in the mid-1980s. These are unusually weak studies. All three are macro econometric studies that involve multivariate regression analysis of aggregated data obtained from standard sources, e.g., state licensure programs, American Hospital Association surveys, and Medicare data. All are burdened by the inherent weaknesses of such examinations of the health care system. Concerns include whether the factors being examined are actually being measured, whether the data used are accurate, reliable, or relevant, and whether the methods used are actually applicable to the question raised. For example, though undertaken in the mid-1980s, the health service and cost data examined in the three FTC staff reports comes from 1977-78 (Noether, Hospital Competition), 1981 (Anderson, Home Health Care Costs), and 1983-84 (Sherman, Hospital Costs).

Underlying assumptions that planning and CON regulation of certain capital costs had (or could have) readily discernible effects in such a short period (PL 93-641 was enacted in 1974 and implemented in 1976) are problematic, attempts to account analytically for these deficiencies notwithstanding. The accuracy and reliability of the data used in these studies are equally questionable. If ever of any value, all three have been eclipsed by changes over the last two decades and have lost any relevance they may have had. Repeated citation by the FTC does not improve or add to the credibility of these studies, or of similar reports that have been cited repeatedly but conflict with experience.

Virtually all of the arguments against CON made by the FTC to State policymakers have been conjecture, based on theory and doctrine rather than acknowledged fact or demonstrated cause and effect. There are few reliable studies of the effects, if any, on the costs and charges for services subject to CON regulation. The results of studies that have been performed have been mixed. In the 1980s, when the FTC staff made representations about the negative effects of CON regulation on access, quality, innovation, and system efficiency, there were few, if any, studies or data that supported these arguments. They were assertions derived from an abiding faith in the effectiveness and unalloyed good of market forces.

Even today there are few studies that try to assess objectively the effects of CON regulation on regulated services. Whatever the purported results, all are regression and correlation studies that do not demonstrate or explain cause and effect. Recent studies that try to discern quality effects of CON regulation generally favor CON regulation.²² Notwithstanding the repeated claims of FTC staff, there are still no reliable studies that show negative access, innovation, or system efficiency

²¹ Recent favorable reports of lower automaker health care costs in states with CON programs, and reports of lower open-heart surgery mortality rates in states with CON programs, are dismissed in this fashion.

²² See, for example, General Motors Corporation. Statement of General Motors Corporation on the Certificate of Need (CON) Program in Michigan, February 12, 2002; Ford Motor Company. Relative Cost Data vs Certificate of Need (CON) for States in Which Ford has a Major Presence, February, 2002; DaimlerChrysler Corporation. Certificate of Need: Endorsement by DaimlerChrysler Corporation, February 2002. Vaughan-Sarrazin, MS, Hannan, EL, Gornley, CJ, Rosenthal, GE. "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation," JAMA, Vol. 288 No. 15, October 16, 2002, 1859-1866.

effects of CON regulation. Statements to the contrary notwithstanding, these are doctrinaire assertions, not demonstrated fact.

IV. Allusive Arguments

The FTC assertion that, rather than helping control costs, "there is considerable evidence" that CON "can actually drive up prices by fostering anticompetitive barrier to entry" is not supported by credible evidence. This uncorroborated assertion is typical of the argument presented. No source for this conclusion is cited. The language, like the argument itself, is in the subjunctive, opaque and indirect. Considerable evidence is not otherwise defined or identified. So-called "anticompetitive barriers," such as CON, are not clearly distinguished from barriers such as licensure and insurance payment rules and regulations that, though they limit or otherwise affect market entry as forcefully as CON regulation, presumably do not rise to the level of being an "anticompetitive barrier".

The opaque assertion that CON "can actually drive up prices" permits the writers to project their views without having to meet the burden of proving them. Orthodox economic theory holds that market entry barriers "can," and often do result in higher prices in many markets, but there is no credible evidence that CON has, or necessarily does, lead to higher costs in health care. Recourse to theory is necessary if the argument is to appear plausible. In other words, if there is not evidence to document the practice or effect, simply assert repeatedly the belief or theory.

V. Related Opinions and Findings

The attack on CON, though sharp, is a small part of *Improving Health Care*. Perhaps more problematic are the related assumptions, beliefs and recommendations that, if implemented, would undermine community and regional planning, and subject those in need of health services to the vagaries of unfettered market forces. These views and assumptions include:

- *Opposition to Internal Subsidies (Cross-subsidies)*. The report recommends that governments (federal and state) re-examine their support of policies and practices that underlie cross-subsidies in health care markets. The rationale offered for this recommendation is that internal (service-to-service) subsidies are inefficient and have the "potential to distort competition."

The report is indifferent to the implications of the loss of service to those who now benefit from these subsidies, noting that "competition cannot provide resources to those who lack them; it does not work well when certain facilities are expected to use higher profits in certain areas to cross-subsidize uncompensated care." If there is a genuine commitment to assist those benefiting from cross-subsidization, the necessity of such assistance should be weighed and, if found meritorious, be provided directly to recipients (presumably through direct payment or vouchers) because that approach would be "more efficient" and "transparent". There is no discussion of the practicality of this approach or of the likely effects on current beneficiaries of subsidies. The net social and health system gain (benefit) of eliminating cross-subsidization is assumed to be positive.

- *Health Insurance Distorts Markets and Competition*. The report does not recommend specific changes in the Medicare program or in other health insurer coverage or payment practices, but asserts repeatedly that insurance coverage and payment

practices, particularly those of the Medicare program ("government administered pricing"), interfere with market forces and competition.²³

The report cites approvingly the commentary of Newt Gingrich that "the third party payment model is inherently conflict ridden"²⁴ and that these insurance schemes "distort incentives and have unintended consequences". According to the report, these distortions explain the rise of ambulatory surgery centers and single-specialty hospitals, particularly cardiovascular services specialty hospitals. The import of the argument is that both Medicare and other third party payers are problematic because they shield individuals from the economic effects and implications of their health care choices and use. From the FTC perspective, if third party payment is to be permitted, high deductible and high co-payment coverage structures are desirable.

- ***Government Purchasing of Services.*** The report is highly skeptical of government purchasing of health care services on behalf of citizens, because it shields the recipient of such care from the disciplining effects of market forces. Hence, although neutrality is claimed on possible financing schemes, the authors warn against single-payer financing arrangements on the grounds that "government purchasing that reflects monopsony power would likely reduce output and innovation."²⁵ The report makes clear that this and related concerns apply to both the existing Medicare and Medicaid programs and to any expansion of them such as any effort (e.g., government purchasing or regulation) to control the costs of, or improve access to, prescription drugs.
- ***Physician Self-Referral.*** Although the FTC and DOJ are charged with preventing monopoly and rooting out restraint of trade practices, and oppose collective bargaining among independent physicians on these grounds, they show little concern about self-referral among physicians. They note approvingly that single-specialty hospitals (SSHs) established recently in states without CON programs "differ from their predecessors in that many of the physicians who refer patients have an ownership interest in the facility." Rather than question this arrangement, or examine carefully the significance of physician-driven decisions in health care and the underlying incentives and practices, the authors "encourage further research into the competitive significance of SSHs." The FTC is especially interested in determining "whether payors can discipline general acute care hospitals by shifting a larger percentage of patients to SSHs."²⁶
- ***Excess Capacity.*** Stated simply, the "Roemer effect" is not recognized by the FTC. As indicated in its recommendation to the New York City Health Systems Agency, a market driven system does not have, or will not long have, excess capacity. According to market

²³ "Any administered pricing system inevitably has difficulty in replicating the price that would prevail in a competitive market. Not surprisingly, one unintended consequence of the CMS administered pricing systems has been to make some hospital services extraordinarily lucrative and others unprofitable. As a result, some services are more available (and others less available) than they would be in a competitive market." *Improving Health Care: A Dose of Competition, Executive Summary*, p. 9.

²⁴ "A large majority of consumers purchase health care through multiple agents. This multiplicity of agents is a major source of problems in the market for health care services. Agents often do not have adequate information about the preferences of those they represent or sufficient incentive to serve those interests." *Improving Health Care: A Dose of Competition, Executive Summary*, p. 11.

²⁵ *Improving Health Care: A Dose of Competition, Executive Summary*, p. 20.

²⁶ *Improving Health Care: A Dose of Competition*, Chapter 3, p. 18.

theory, some level of surplus capacity—the level to be determined by market forces—is necessary for a competitive system. FTC staff assumes that the market will punish, and ultimately root out, surplus capacity, inappropriately low occupancy levels, and inefficiency (e.g., low throughput). In other words, there cannot be too many hospitals, hospital beds, or too much service capacity of any kind in a free market.²⁷

VI. Supportable Report Findings and Recommendations

- ***Information Asymmetry.*** The report recognizes that a major imperfection in the current system is the lack of accurate and reliable cost and quality information consumers can use in seeking health services. The recommendation for a concerted, system-wide effort to make more of such information available is commendable. Unfortunately, the report does not recognize or acknowledge that knowledge and information asymmetry is inherent (unavoidable), nor does it suggest ways to deal with this question.
- ***Enhance Incentives to Lower Costs and Improve Quality.*** The recommendations offered in the report are generic in nature and unobjectionable. The need to improve incentives to reduce or control costs, and to improve quality is recognized and accepted by nearly everyone. Unfortunately, little guidance is offered about the specific questions to be addressed, the means to address them, or the problems likely to be encountered in dealing with them.
- ***Implement Institute of Medicine Licensure Reforms.*** The suggestion that the membership, and consumer representation on state health facility and service licensing boards be broadened is laudable. Both the scope and substance of licensing decisions, and the processes used in making them, need reform.

VII. Problematic Report Findings and Recommendations

- ***Eliminate CON Regulation.*** The recommendation that CON programs be eliminated is based largely on doctrine. The argument is a repackaged version of decades-old FTC arguments and positions. No new studies or analyses are offered. Empirical evidence and recent studies and experience showing the benefits of CON regulation are largely dismissed, not disproved.
- ***Re-examine Subsidies in Health Care Services.*** The value of all health care policies and practices should be examined periodically as a matter of course. In fact, most are. The underlying FTC argument against cross-subsidization is based on orthodox economic doctrine, not on an assessment of their intrinsic merit or the rationale for them. Most subsidies are in place for notably laudable purposes. Some, perhaps all, may need to be reconsidered, but not for theoretical or doctrinal reasons. The evolved connection between cross-subsidization, provision of charity care, and CON review contingencies and conditions is of considerable social value. Current practices should not be changed unless meaningful alternatives are in place.

²⁷ Jeffrey Zuckerman, Director, Bureau of Competition, U. S. Federal Trade Commission, to Giri Vuppala, Assistant Director, Planning and Implementation, Health Systems Agency of New York City, February 9, 1987.

- ***Prohibition of Physician Collective Bargaining.*** Though a relatively small issue, the argument against collective bargaining among independent physicians is doctrinal in nature. The presumed negative effects of collective bargaining on quality and costs are theoretical. The FTC position appears to be more a statement of the Commission's social views, not one based on analysis or evidence.
- ***Regulation of Pharmacy Benefits Manager Transparency.*** The problems with prescription drug prices, and with obtaining reliable information about their efficacy and cost, are manifest. The FTC recommendation that there be no government regulation of pharmacy managers appears to be an attempt at preemption. The argument and recommendation are illustrative of the doctrinal nature of the FTC positions. The report acknowledges that accurate and reliable information is necessary, but rejects government action to ensure that such information is available to payers and consumers. It falls back on the doctrinal argument that a free market should be relied on to produce the information that is needed to discipline the system.
- ***Service mandates.*** As with cross-subsidization, the FTC argument against service mandates is based largely on orthodox economic theory, and hence doctrinal in nature. There is no meaningful analysis of the rationale for, the value of, or the costs of mandates compared with alternatives. The merits and costs of service coverage mandates should be reviewed periodically, but eliminating them in the name of economic orthodoxy is not warranted.

VIII. Arguments Against FTC Assertions and Assumptions

- ***The health care market is inherently imperfect.*** The FTC recognizes that the usual benefits of competition are not achievable in the health care system under current conditions. The report acknowledges a number of glaring market imperfections that need to be cured if market forces and competition are to have their presumed beneficial effects. The problems cited include the mediating influence of service selection and purchasing intermediaries such as insurance, Medicare, physicians and other health care professionals, the lack of price and quality information, legislatively imposed service mandates, cross-subsidization within the system, and service to all in urgent and emergent circumstances regardless of ability to pay.

The report argues that these imperfections should be cured as quickly as possible. Whatever the merit of this view and argument, cures are not likely soon. Even if acted upon aggressively, the changes required would take years to accomplish in most cases. Community-based planning and CON regulation are linked to, and help compensate for, a number of these imperfections. It is important to maintain and strengthen planning and targeted CON regulation until the related market imperfections are corrected.

- ***Health care is not, and should not be treated as, a commodity.*** Although the FTC does not state directly that health care should be treated as an economic commodity, its arguments and assumptions make practical sense only if that were the case. Even in theory, much less in practice, market forces can have the system-shaping effects the FTC calls for, and argues will result from unfettered competition, only if health care is treated as any other economic good. The report laments that many, if not most, people see health care as "a special good" that is not, and should not be, subject to orthodox market forces. The

positive aspects of planning, CON regulation, facility licensure, and a number of other mediating social constraints are in place, in part, because market forces do not, and probably cannot, be used to discipline this market.

- *The studies critical of CON cited by the FTC are not reliable.* The argument that planning and CON regulation result in higher costs and prices, inferior quality, reduced access, less innovation, and lower operating efficiency, though asserted repeatedly, is not supported by demonstrated fact. This refrain is based largely on an unwavering adherence to orthodox economic doctrine.

Most of the sources cited that purportedly show negative economic and quality effects of CON regulation, are FTC staff reports and FTC staff statements, which, in turn, are often based on these studies. Thus, many of the citations are self-referential. The base studies themselves are suspect. The data used, the timeframes covered, and analytical processes relied upon are problematic. The conclusions drawn are debatable. Based on multivariate regression analysis and statistical correlation, none of these "studies" demonstrates cause and effect and, beyond theoretical conjecture, none explains the method or mechanism by which the changes observed were achieved.

Analyses that try to examine the economic and quality effects of CON regulation yield mixed findings, not the uniformly negative results asserted in the FTC report. Contrary to the impression conveyed in the FTC report, there are no reliable studies showing the effects of CON regulation on access to care, system efficiency, innovation, or other specific system characteristics.

- *Empirical evidence and experience are ignored or treated dismissively.* The recently reported experience of U.S. automakers showing lower costs in States with CON programs, and published analyses showing significantly lower mortality rates among open-heart surgery patients in States with CON programs, are dismissed. This information, when acknowledged, is usually cited in the testimony of a commentator or hearing panel member and dismissed by pairing it with opposing anecdotal testimony of CON critics.
- *Health care as a privilege.* The FTC prides itself on working in the interest of the consumer, the average citizen. It argues that "consumer-driven" health care system is desirable and possible if market forces are permitted free reign. The paean to consumer control, though superficially attractive, borders on the disingenuous when examined in the light of economic and health system realities. The report prescribes theoretical cures to real problems. The discussion is at the macroeconomic level. The assumption appears to be that, if you address, at least theoretically, overarching system questions and imperfections, maximum benefit will flow (trickle down) to the individual.

Unfortunately, the individual is treated as a theoretical economic entity or construct. Market realities are such that, under FTC prescriptions access, to quality health care would become a privilege, not a right or reasonable social expectation, dependent upon the economic standing, the knowledge base, and the social status of the individual. The report appears to anticipate and endorse this outcome. It speaks approvingly of consumers needing incentives to "balance costs and benefits and search for lower cost health care with the

level of quality that they prefer."²⁸ Presumably, the poor might "prefer" a "level of quality" consonant with what they could afford. As with any other commodity, an unfettered health care system will offer many different quality levels or categories, in both clinical and economic terms.

IX. Arguments in Favor of Planning and CON Regulation

- CON is a useful market balancing tool. In a necessarily imperfect, and an increasingly inequitable, health care system, community-based planning and CON regulation are flexible tools that, when used intelligently and objectively, help protect the critical health care infrastructure that is required to meet both expected and unanticipated public need. Market forces are invaluable in balancing the cost, supply, access, and quality of most goods and services. Market fluctuations and vagaries are acceptable for most commodities, but are problematic for essential social goods and services, especially health care.
- Under current and expected health system market conditions, community-based planning and CON regulation are useful in promoting competition. CON regulation, and related planning, can be and has been used to provide consumers and other purchasers with price and quality information. They also are used to stimulate direct competition and market entry where evidence indicates this would improve system operations and efficiency.
- Recent empirical evidence shows substantial economic and service quality benefit from CON regulation and related planning. Empirical studies by all three major U.S. automakers show substantially lower health care costs in states with CON programs.²⁹ Similarly, the most recent and largest study of CON regulation on treatment outcomes found that open heart surgery mortality rates are more than 20% lower in states with CON regulation than in states without regional planning and regulation.³⁰
- CON regulation is one of the few practical planning tools available to policymakers. Whatever its limitations, CON regulation, with related community-based planning, is one of the few tools that policymakers, health system officials, and ordinary citizens have available for use in trying to compensate for known weaknesses and deficiencies in the existing health care system. CON decision-making processes provide a unique forum where all interested parties, and ordinary citizens, can express their views and state their needs. This oversight is distinct in that it often is the only light available to illuminate important quality, cost, and access concerns that are important to consumers.
- CON regulation is the only practical tool available to implement basic planning policies and practices. The relationship between average annual service volume and treatment

²⁸ *Improving Health Care: A Dose of Competition, Executive Summary*, p. 5.

²⁹ General Motors Corporation. *Statement of General Motors Corporation on the Certificate of Need (CON) Program in Michigan*, February 12, 2002; Ford Motor Company. *Relative Cost Data vs Certificate of Need (CON) for States in Which Ford has a Major Presence*, February, 2002; DaimlerChrysler Corporation. *Certificate of Need: Endorsement by DaimlerChrysler Corporation*, February 2002.

³⁰ Vaughan-Sarrazin, MS, Hannan, EL, Gormley, CJ, Rosenthal, GE. "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation," *JAMA*, Vol. 288 No. 15, October 16, 2002, 1859-1866.

outcome is well known. It has been documented repeatedly for many of the services regulated under CON programs. CON regulation is the most reliable and practicable tool for implementing service, institutional and regional planning policies and practices that facilitate and ensure appropriately high program volumes.

X. Conclusions

Improving Health Care: A Dose of Competition appears to be largely a political treatise. It is not an analytical study. The underlying purpose appears to be an attempt to frame (shape) the debate over the nature and evolutionary direction of the U.S. health care system. It touts a "consumer driven" system as the ultimate goal. The report argues that this is possible if the nation has the courage to forgo internal subsidies, service mandates, over-reliance on insurance and government financing and purchasing, government regulation, and associated practices. Reliance on unrestrained market forces is prescribed as the best approach to determining health care capacity, cost, quality, and access. The negative effects of unfettered competition are not examined.

In terms of health planning and CON regulation, the report repackages and restates decades-old arguments against regulation. No new data, information or analysis is offered, and empirical evidence indicative of the efficacy of CON regulation and associated planning is dismissed. By almost any measure, the presentation is largely doctrinaire, based on an unwavering belief in the applicability of orthodox economic doctrine in health care rather than an objective analysis of market realities and experience.

The stated FTC goals of market efficiency, consumer control and informed stakeholders have been integral to community-based health planning for more than 40 years. The community has always been, and remains, an integral part of the planning, development and regulatory processes. The principal difference between FTC beliefs and assumptions, and those favoring planning and targeted regulation is how best to manage the tension between public and private interests, and between short-term and long-term perspectives and incentives. AHPA has always believed in the importance of community-oriented health care services and systems, and encourages ongoing reassessment of health planning and CON regulation to ensure they remain responsive to technological change, evolving health care practices, and community values and needs. The Association will continue to support these principles and practices.



REASONS FOR CONTINUING CERTIFICATE OF NEED IN ALASKA

- **Health care is not a conventional market; its economic forces are different.**
 - Health care has a finite need in each community. Introduction of additional medical providers redistributes finite revenue among more providers with 'winners and losers' in the community. Community hospitals will be the 'losers' as profitable services are aggressively sought by new imaging, surgery and specialty hospital providers. This will have profound adverse impact on their ability to fully meet community expectations.
 - Hospitals and nursing homes must offer a full range of outpatient, inpatient and emergency services 24 hours a day, 7 days a week, 365 days a year. A number of these essential services do not produce adequate revenue to offset their cost of operation yet they must be offered to fully meet the needs of the community.
 - Health care is heavily regulated by federal & state laws. These regulations do not afford the health care provider the same flexibility and efficiency found in other markets. For example, a reduction in profitable service lines cannot be recovered by increased pricing as nearly one-half of hospital revenue comes from sources that set their own pricing (Medicare and Medicaid).
 - There is no assurance that introducing additional health care providers in a community will reduce cost to the consumer. In fact there is recent research that continues to suggest otherwise.
- **Hospitals must serve all persons in the community that need care regardless of ability to pay and are the key responder in community disaster response.**
 - Without CON, specialty providers can enter the market and create unfair competition by offering only the most profitable medical services and limiting the number of non-paying and underinsured patients that they will see.
 - 18 of Alaska's 25 hospitals are 'sole community providers' which risk financial instability and irreparable harm to community residents if the State does not insure that there is need for more health care infrastructure before it is introduced into the community.
 - Hospitals invest preparedness funds and extensive training to serve the community in event of natural disasters, pandemic flu, biological, and chemical threats. These expenses are not recovered from health care purchasers and only partially offset by federal/state grants. CON helps assure these important services will not be threatened by loss of critical revenue to keep these protections in place.

• CON is an important health policy tool that balances community need with growth.

- There are many examples of health care projects initiated in communities around the country where "profit" motives take priority above overall "community good". The CON review process focuses on these issues and assures the project is in the best interest of patients as well as the community.
- Without a strong CON process, over-building of health care services will occur in some areas, while critically needed medical services will not be developed in other areas. Developers will go into geographic areas where they see an opportunity, not into areas where they see marginal return on investment.
- 36 states plus the District of Columbia continue to require CON approval for one or more categories of health services. Further, some states have gone beyond CON and put moratoriums in place to prohibit growth in certain medical services.

• Current CON laws are not preventing needed growth in Alaska's health care infrastructure,

- Since reopening of the CON process in 2005, the Department of Health & Social Services has approved a number of new health care projects and has allowed others to proceed without CON review.
- Alaska's hospitals and nursing homes are required to apply for CON approval before embarking on any new expansion project. Other parties interested in providing health care services should be exposed to the same rigorous review with the exception of 'physician offices' which are exempted from CON under current law.

• Over building of medical infrastructure will worsen Alaska's workforce shortage.

- Alaska is already facing a critical shortage of physicians and nurses. This situation is not expected to improve in the short term. Many of the projects subject to CON review would require the most specialized professionals in radiology and surgery.
- If we do not control the growth in Alaska's medical infrastructure we will see staffing shortages in our hospitals and nursing homes beyond anything we have experienced to date.



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The Effects of Certificate-of-Need Repeal on Medicaid Long-Term Care Expenditures.

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Abstr Acad Health Serv Res Health Policy Meet. 2001; 18: 99.

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RESEARCH OBJECTIVE: Certificate-of-need (CON) programs have been widely used to control the growth in nursing homes and thereby limit state Medicaid expenditures. However, CON policies have been found to be associated with lower nursing home quality and restricted access to services for Medicaid recipients. In recent years, a number of states have repealed their CON laws as they apply to nursing homes. This study examined the effects of these CON repeals on Medicaid long-term care expenditures. **STUDY DESIGN:** We estimated a set of regression equations using a pooled time series of state level Medicaid long-term care expenditures from the period 1981 through 1996. The analysis is complicated by the fact that CON repeals and other Medicaid programmatic variables are simultaneously determined with Medicaid expenditure levels. Thus, we estimated both a simple one equation model and a two-stage least squares model, which accounts for the simultaneity issue. **PRINCIPAL FINDINGS:** Using either a simple one equation model or the more complex multi-equation approach, preliminary analyses provided no evidence that Medicaid long term care expenditures increased when CON laws were repealed. In fact, our analyses indicated that CON repeal was associated with lower Medicaid expenditures. The data also suggested that it has been the level of Medicaid nursing home payment that has been the policy variable responsible for lower Medicaid expenditures. **CONCLUSIONS:** This paper provided evidence that the repeal of CON legislation has not led to significantly higher Medicaid long-term care expenditures. Implication for Policy, Delivery, or Practice: There is a large literature that concludes hospital CON laws are ineffective at constraining public expenditures. Nevertheless, Medicaid policymakers have always assumed that CON reduced nursing home expenditures. This study suggests that state Medicaid programs may wish to re-visit the use of CON programs as they pertain to nursing homes.

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THE EFFECTS OF COMPETITION ON VARIATION IN THE QUALITY AND COST OF MEDICAL CARE

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We estimate the effects of hospital competition on the level of and the variation in quality of care and hospital expenditures for elderly Medicare beneficiaries with heart attack. We compare competition's effects on more-severely ill patients, whom we assume value quality more highly, to the effects on less-severely ill, low-valuation patients. We find that low-valuation patients in competitive markets receive less intensive treatment than in uncompetitive markets, but have statistically similar health outcomes. In contrast, high-valuation patients in competitive markets receive more intensive treatment than in uncompetitive markets, and have significantly better health outcomes. Because this competition-induced increase in variation in expenditures is, on net, expenditure-decreasing and outcome-beneficial, we conclude that it is welfare-enhancing. These findings are inconsistent with conventional models of vertical differentiation, although they can be accommodated by more recent models.

1. INTRODUCTION

Recent studies have emphasized the importance of vertical differentiation in markets for hospital services. Yet, most analyses of how hospitals compete do not investigate competition's effects on hospitals' strategic choice of quality of care. In this paper, we estimate empirically how

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conventional measures of hospital market competitiveness affect the distribution across patients of health outcomes and medical expenditures. This contributes to the existing literature in at least three ways.

First, different theoretical models offer opposing predictions of how competition affects vertical differentiation. Thus, empirical evidence can be used to test such models against one another. Second, estimates of the effect of competition on vertical differentiation are important for policy making. For example, understanding whether competition benefits all patients equally, or benefits some patients at the expense of others, improves the targeting and coordination of antitrust and other health care quality regulatory policies. Third, many researchers have argued that the substantial variation in the cost of medical care across geographic areas is socially wasteful (see Fisher et al., 2003 for a comprehensive cataloging of this work). Estimates of the effect of competition on area variation in quality and cost can therefore indicate whether at least a portion of this variation is socially constructive or harmful.

In particular, we investigate how competition in hospital markets, as measured by a Hirschman-Herfindahl index (HHI), affects the health care utilization and outcomes of essentially all non-rural elderly individuals enrolled in traditional fee-for-service Medicare who suffered a new heart attack (AMI) between 1985 and 1996. We estimate the extent to which the HHI has different effects on patients with prior year hospital utilization and those without it, holding constant five-digit-*zip*-code fixed effects and other characteristics of individuals and hospital markets. Because the health outcomes of prior-year-hospitalized AMI patients are substantially worse (and their utilization substantially higher), we describe them as "high-risk" and their prior-year-nonhospitalized counterparts as "low-risk". Consistent with previous research (e.g., Capps et al., 2003), we assume that high-risk patients have a higher willingness to pay for quality than low-risk patients. By examining how the HHI affects each of these two groups' subsequent outcomes and expenditures, we explore both how competition affects variability in quality and how this competition-induced change in vertical differentiation affects social welfare.

The paper proceeds as follows. Section 1 briefly summarizes the previous research on this subject. Section 2 outlines our data and models. Section 3 presents our results. Section 4 concludes.

2. PREVIOUS RESEARCH

Eliminating an independent competing hospital from a market changes neighboring hospitals' strategic incentives, thereby changing the types

of treatment, prices, and qualities that they offer. According to this reasoning, the welfare effect of a change in competitiveness, such as a proposed merger, is determined by comparing the quality of and expenditures on treatment in competitive and uncompetitive markets, holding all other observed factors constant (e.g., Kessler and McClellan, 2000).

Yet, as Tay (2003) shows, such an analysis is not a complete description of how hospitals compete. Quality may not be wholly endogenous. For example, if some hospitals are permanently high quality and others permanently low quality, then the effects of mergers may not be accurately predicted by a model that fails to account for vertical differentiation. In addition, even if quality is endogenous, simply knowing the average or total effect of a change in competition leaves many important issues unresolved. Changes in competition may benefit patients in aggregate but still harm some subgroups.

Theoretical models of vertical differentiation illustrate how this can happen. Conventional models (e.g., Gabazewicz and Thiese, 1980; Shaked and Sutton, 1982) emphasize how oligopoly increases quality variation at the expense of social welfare: firms try to relax price competition through differentiation (see Tirole, 1989, section 7.5.1. for an excellent exposition of these models). In markets for hospital services, these models imply that oligopoly hospitals lower the quality of care for low-risk (i.e., low-valuation) patients in order to be able to charge their high-risk (i.e., high-valuation) counterparts more. In the terms of our empirical models, competitive markets should have less variation in quality and expenditures, lower rates of mortality and cardiac complications for low-risk patients, and lower expenditures for high-risk patients.

In more recent work, however, Acharyya (1998) shows that without restrictions on cost functions, uncompetitive markets may or may not have more quality variation. Indeed, in an oligopoly model incorporating both horizontal and vertical differentiation, Anderson and De Palma (2001) show that under certain assumptions the unique equilibrium has all firms choosing a single (sub-optimal) quality. In the terms of our empirical models, more recent work allows uncompetitive markets to have higher rates of adverse outcomes and lower expenditures for high-risk patients, or low-risk patients, or both.

In this paper, we empirically test the hypotheses of these models. We separate patients into two groups: those with a low versus a high valuation of quality based on a measure of their health status at the time of onset of illness. By estimating the effect of concentration on the mortality, cardiac complications, and medical expenditures of low- and high-valuation patients, and for patients overall, we investigate the

extent to which conventional models of vertical differentiation explain behavior in hospital markets. In addition, these estimates allow us to identify the welfare consequences of competition-induced variation in quality. If an increase in variation leads to lower expenditures and better outcomes, then we conclude that it would increase welfare. If it leads to higher expenditures and worse outcomes, then we conclude that it would decrease welfare. If it leads to lower expenditures and worse outcomes (or higher expenditures and better outcomes), then we calculate the implied cost per life saved to determine its welfare effects.

3. DATA AND MODELS

3.1 DATA

We use data from three sources. First, we use comprehensive individual-level longitudinal Medicare claims data from the Centers for Medicare and Medicaid Services (CMS) on the medical utilization of virtually all nonrural elderly fee-for-service Medicare beneficiaries with a new occurrence of a heart attack (AMI) in 1985–1996. We determine whether the individual had acute care hospital utilization in the year prior to his or her AMI as a measure of the severity of his or her illness. We calculate several measures of utilization in the year after the individual's AMI, including the following: total acute and non-acute (mostly skilled nursing) Medicare expenditures (including deductibles and co-payments) and total acute and non-acute days in the hospital in the year following their admission for the study illness. Measures of utilization include all inpatient reimbursements (including co-payments and deductibles not paid by Medicare) from claims for all hospitalizations in the year following each patient's initial admission. Measures of the occurrence of cardiac complications were obtained by abstracting data on the principal diagnosis for all subsequent admissions (not counting transfers and readmissions within 30 days of the index admission) in the year following the patient's initial admission. Cardiac complications included re-hospitalizations within 1 year of the initial event with a primary diagnosis (principal cause of hospitalization) of either subsequent AMI or heart failure (HF). Treatment of AMI patients is intended to prevent subsequent AMIs if possible, and the occurrence of HF requiring hospitalization is evidence that the damage to the patient's heart from ischemic disease has serious functional consequences. Data on patient demographic characteristics were obtained from CMS's HISKEW enrollment files, with death dates based on death reports validated by the Social Security Administration. The CMS HISKEW enrollment files include demographic information on virtually all elderly Americans (including those enrolled in Medicare HMOs) because of the extremely high rate of take-up in the Medicare program.

Second, we use data on US hospital characteristics collected by the American Hospital Association (AHA). The response rate of hospitals to the AHA survey is greater than 90%, with response rates above 95% for large hospitals (>300 beds).

Third, we use a hospital system¹ database constructed from multiple sources (see Madison, 2001 for a detailed discussion). The AHA survey contains extensive year-by-year information on hospital system membership status. Our validity checking indicated that the universe of systems and system hospitals, and the timing of hospitals' system membership, as defined by AHA did not conform to discussion of hospital systems in the trade press such as *Modern Healthcare*. We, therefore, created our own system database based on a combination of the AHA and other sources.

3.2 MODELS

We model the effect of competition on the level and the dispersion between high-risk and low-risk patients of quality and medical expenditures. We identify the effect of competition with an HHI that is a function of distances from each patient to his hospital choices and other exogenous characteristics of patients and hospitals. To do this, we use a three-stage method.²

First, we specify and estimate patient-level hospital choice models as a function of exogenous determinants of the hospital admission decision. We do not constrain hospital geographic markets based on a priori assumptions. We allow each individual's potentially relevant hospital market for cardiac-care services to include all nonfederal, general medical/surgical hospitals within 35 miles of the patient's residence with at least five admissions for AMI, and any large, non-federal, general medical/surgical teaching hospital within 100 miles of the patient's residence with at least five AMI admissions. We model the extent to which hospitals of various types at various distances from each patient's residence affect each patient's hospital choice, and we also allow each patient's demographic characteristics to affect his or her likelihood of choosing hospitals of one type over another. The results of these models of hospital demand provide predicted probabilities of admission for every patient to every hospital in his or her potentially relevant geographic market. We then estimate the predicted number of patients admitted to each hospital in the US, based only on the geographic distribution and other observable, exogenous characteristics of patients and hospitals.

1. We define hospitals as members of a system if they are owned or controlled, in whole or in part, by a common entity.

2. The following explanation follows the explanation in Kessler and McClellan (2000); that paper also contains a formal derivation of these methods.