The Federal Trade Commission
&
Certificate of Need Regulation

An AHPA Critique

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. . . putting it all together

Table of Contents

I	Overview	3
II	Context & History	4
III	Nature of the FTC Critique	6
IV	Allusive Arguments	9
V	Related Opinions and Findings	9
VI	Supportable Report Findings and Recommendations	11
VII	Problematic Report Findings and Recommendations	11
VIII	Arguments Against FTC Assertions and Assumptions	12
IX	Arguments in Favor of Planning and CON Regulation	14
X	Conclusions	15

I. Overview

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

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

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

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

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

[2] *Ibid.*

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

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

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[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 Georgia[7], Hawaii[8], Maryland[9], Michigan[10], Nebraska[11], New York[12], North Carolina[13], Ohio[14], Pennsylvania[15], 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 early1987, 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."

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[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

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[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, 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.

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 affects 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

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[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 polices 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.

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[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 oversiight 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

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[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.