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Introduction

The American Health Planning Association (AHPA) appreciates the renewed interest of the Federal Trade Commission (FTC) and the U. S. Department of Justice (USDOJ) in the structure and functioning of health care markets. We note the critical role these agencies played in the late 1990's in the dissolution of many hospital mergers that were not in the public interest.[1] With this achievement in mind, we were heartened by the announcement last summer of the establishment of a rejuvenated FTC Merger Litigation Task Force. Amplification of that action through these hearings is welcome.

AHPA supports interrelated community-based planning and targeted regulation that takes fully into account the realities of health care markets. This combination of planning and regulation promotes economic efficiency and quality, as it tries to ensure system responsiveness to the needs and interests of both consumers and providers of health care services. The necessary balance between open competitive markets and essential community-based planning and regulation is becoming more difficult to maintain. Powerful economic interests, increasingly unchecked and employing more aggressive tactics and practices, are pursing private gain at the expense of individual and community well being.

It comes as no surprise to most that many of the problematic practices and excesses of the marketplace have found their way into health care. Under the guise of promoting competition and consumer choice, major health care corporations, especially niche and boutique service operators, have become increasingly inventive and aggressive in

segmenting and dominating markets, geographically and economically. We believe there is a real danger of some providers dominating, virtually monopolizing, more affluent market sectors as they undermine essential community hospitals and related services that serve the entire community all of the time. These tactics and their effects warrant the closest scrutiny.

It is likely that during these hearings some will attack health services planning, and particularly certificate of need (CON) regulation, as an unnecessary barrier to market entry that encourages or rationalizes monopolistic behavior. Listen respectfully to their rhetoric, but examine their claims and data, if any, carefully. Doctrinaire criticism of CON as unnecessary and unproductive regulation has been commonplace for nearly four decades. These critics have been joined, on occasion, by some academics, and by many of those seeking gain through market segmentation and manipulation. The intensity of the debate has fluctuated as the sociopolitical standing of planning and regulation has waxed and waned. Their zeal notwithstanding, little factual evidence has been developed that substantiates their arguments and assertions.

Recently, data and information have begun to accumulate that discredits this criticism and demonstrates the substantial value of planning and regulation in the provision of health care services. These beneficial economic and quality effects are discussed in some detail in this testimony.

Recent Trends

CON regulation exists, and has endured, in the face of a strong anti-regulatory social and political trend, largely for two basic reasons:

- First, the imperfections of the health care market are necessarily such that some form of community-based planning and regulation appears necessary to achieve minimal policy goals and objectives. There is strong evidence that CON planning and regulation is more useful in promoting competition and market efficiency than in establishing inappropriate barriers to market entry.

- Second, notwithstanding more than three decades of jaundiced criticism and questionable econometric studies, some from provocateurs associated with the FTC, CON regulation appears to work. Both economic and qualitative benefits are being seen.

More than two-thirds of the states now have some form of planning and CON regulation. The scope and focus of coverage varies widely among states (PowerPoint Slides 8-11).[2] Nearly all of the states that eliminated or reduced the scope of CON regulation significantly did so in the decade between 1986 and 1996 (PowerPoint Slides 8 & 9). There has been comparatively little substantial change in these patterns and trends over the last five to six years.

There are distinctive regional patterns and variations among state programs, and these continue to evolve. It is notable that these patterns correlate generally with political demography. Whatever their specific scope and focus, conceptually, state CON programs are similar in that they are distinguished by the following purposes:

- Support community-based health services and health facility planning;
- Encourage community-oriented planning by health service program operators;
- Function as a plan implementation tool;
- Counter the "excess capacity generates excess demand" phenomenon;
- Limit unnecessary capital outlays; and
- Provide analytical discipline and goal orientation in health service planning at all levels.

Any assessment of the value and utility of CON regulation needs to take these underlying purposes and effects into account (PowerPoint Slides 12-19).

Market and Regulatory Distinction: Atypical Regulation

Just as the health care market is not a traditional market that operates by classic economic principles, CON is not commonplace regulation. Some have likened it to public utility regulation, but that is at best an inexact analogy. Unlike other regulatory schemes, CON is grounded in and, ultimately derives its legitimacy from, community-based planning that envisions and involves consumers (purchasers) and providers (producers) of health care services working cooperatively to achieve defined policy goals and service outcomes.

Equally important, unlike licensing and some forms of credentialing, CON regulation is a dynamic process oriented toward sustained enhancement of health system performance. In contrast to the static reductionism inherent in licensure, CON planning values, criteria, and standards are flexible and can be designed to reflect pragmatically evolving technological changes, ongoing research, and emerging best practices. In contrast to licensure and certification, which set minimum thresholds, CON planning and regulation set flexible goals and targets that raise performance levels over time.

CON offers the potential of elevating system performance and treatment outcomes. There is strong evidence, for example, that well planned regional services have higher average program volumes than unplanned facilities and services. Higher average volumes are correlated with cost-effectiveness, lower unit costs, and better treatment outcomes than unplanned services. We site specific examples of these demonstrated benefits below and in the accompanying PowerPoint presentation.

The health care market is distinctive, if not unique. CON regulation is equally atypical, illustrated by several dynamic characteristics and features:

- Planning-based, analytically-oriented, fact-driven;
- Open process, with provision for direct public involvement;
- Structured to compensate for market deficiencies and limitation;
- Imbued with an anti-guild orientation and mentality;
- Unlike licensure or certification, designed to foster market efficiency;
- Promotes economic, access and quality competition, while responding to realities of local service areas and health care markets;
- Practical and educational rather than ideological; and
- Doorway to excellence rather than a barrier to market entry.

Critics acknowledge some of these aspects of CON regulation but argue that countervailing forces and circumstances are such that CON:

- Focuses mostly on ***cost control*** by restricting market entry, capital outlays and technical innovation;
- Looks largely at the ***geographic aspects*** of access rather than broader social and system access questions;
- Does not assume a role in or have a concern with ***quality*** in health services; and
- Is generally unaware of, or indifferent to, the uses and role of ***market forces*** in health services delivery.

On the other hand, a more careful examination of the record suggests that, in most cases, CON:

- Focuses on ***access and quality*** more than cost;
- Seeks to improve ***economic and social access***;
- Promotes ***equal access*** to health care;
- Advocates community, patient and provider ***equity;***
- ***Elevates quality*** with a focus on best practices, high standards;
- Promotes ***fiscal responsibility*** by using sound economic planning principles;
- Maintains a ***responsiveness*** to the realities of market forces and circumstances;
- Supports ***anti-monopolistic*** practices through use of RFPs and ***competitive*** reviews;
- Encourages ***market-integration*** and broad reimbursement availability;
- Promotes ***open-panel*** medical staffing; and
- ***Opposes anti-competitive*** forces and actions such as community abandonment.

Current Findings

Most of the academic studies that have questioned the value of CON as an effective regulatory and planning tool are large econometric studies that attempt to find statistically significant differences among states in hospital capacity or health care costs linked to

CON status. These studies have produced questionable results.[3] Few have attempted to look closely at other important CON uses such as in quality assurance, improving access, and helping insure the stability and viability of essential community hospitals. Similarly, there are few in-depth studies of how CON operates in specific regions or states, or for specific services.

More recent studies have documented substantial quality and economic benefits from community-based planning and CON regulation. Some of these are discussed below (PowerPoint Slides 20-26).

Empirical Evidence: US Automakers

Faced with rising health care costs and the possibility of weakening or eliminating Michigan's CON program, the big three automakers--DaimlerChrysler, Ford Motor Company and General Motors--undertook separate systematic analysis of their health care costs in states where they have large numbers of employees and insured dependents. These studies have special relevance because, unlike academic studies employing econometric methods that may have questionable relevance to variable health care markets, these data reflect the actual experience of similar large multi-state employee groups that have similar benefits programs and comparable health and socioeconomic status. Collectively, these studies analyzed costs in eight states, five with and three without CON regulation.

Each automaker conducted an independent study. All three found that, for each year studied, their health care costs were significantly lower in states with CON regulation than in states without regulation. The automakers presented their findings in early 2002 to committees of the Michigan Legislature considering the future of CON there.

General Motors Experience

General Motors (GM) analyzed health care use and expense data among its employees and dependents in Indiana, Michigan, New York and Ohio, four states where it has large numbers of insured, for the six-year period 1996-2001. During this period, Indiana had had no CON regulation for many years and Ohio repealed its CON program a year earlier, in 1995. Both Michigan and New York have continuously maintained CON programs for more than 20 years.

As shown in Table 1, and Charts 1 and 2, hospital costs among those insured by GM were substantially higher in each of the six years studied in Indiana and Ohio (states without CON regulation) than in Michigan and New York (states with CON regulation).[4] The analysts noted that GM's insured populations, and its health care benefits and cost-sharing provisions, are similar, and that the expenses reported were standardized to an age-adjusted, dollars-per-insured-life basis.

GM noted that, with 1.2 million employees, it spends $4.2 billion each year on health care benefits for its employees, retirees and their dependents. In interpreting its experience, GM stated:

> *Some argue that deregulating health facility expansion will trigger free-market forces of supply and demand and lead to lower costs. On the contrary, General Motors has not found that to be true based on our vast experience in states that have varying degrees of CON regulation.*[5]

General Motors also pointed out the relationship between average service volumes for certain services and quality (treatment outcome), and concluded that CON regulation is an important tool to ensure cost-effective, high quality health care services.

Table 1
Age Adjusted Health Care Expenditures Per Employee*
By State CON Status
General Motors Corporation
1996 - 2001

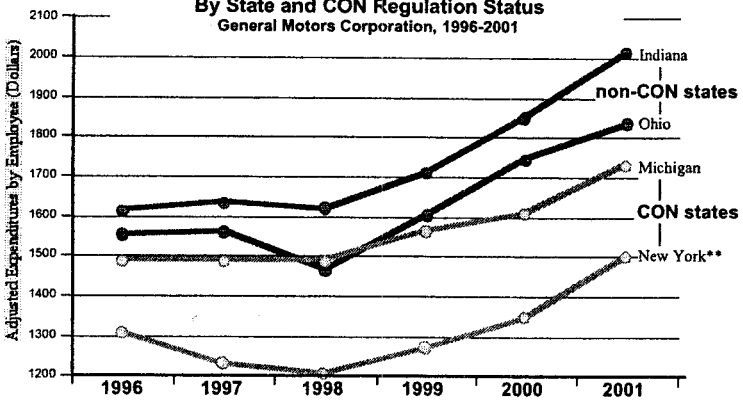
	Expenditures Per Employee							
State	1996	1997	1998	1999	2000	2001	Percent Change 1996 to 2001	CON Status
Indiana	$1,611	$1,629	$1,613	$1,706	$1,846	$2,008	24.6%	*No CON*
Ohio	$1,556	$1,559	$1,465	$1,606	$1,746	$1,834	17.9%	*CON Repealed, 1995*
Michigan	$1,487	$1,487	$1,483	$1,560	$1,606	$1,732	16.5%	*Has CON*
New York	$1,306	$1,228	$1,204	$1,271	$1,347	$1,501	14.9%	*Has CON*

* Includes all hospital, surgical and medical expenses.

Source: *Statement of General Motors Corporation on Certificate of Need (CON) Program in Michigan*, February 12, 2002.

The General Motors study, which also examined relative cost changes over the six years studied, showed that not only were costs higher in states without CON regulation, costs also grew more rapidly in those states as well. The rate of increase over the six years was more than 40% higher in Indiana than in New York, the state with the first and most effective CON program. So, the GM experience found that the relative differential in costs between states with and without CON regulation increased over the study period (Table 1, Chart 2). Costs in states without CON regulation rose faster than in states with regulation.

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



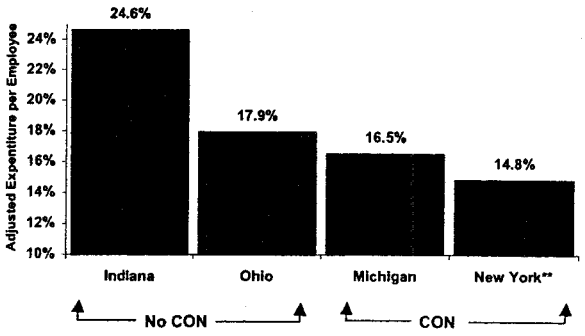
* Includes all hospital, surgical and medical expenses
** First, and most effective, CON program in the U.S.
Source: General Motors Corporation, *Statement on the Certificate of Need Progam in Michgan, 2002.*

Ford Motor Company Experience

Ford Motor Company (Ford) conducted a similar study, titled *Relative Cost Data vs. Certificate of Need (CON) for States in which Ford has a Major Presence*. To ensure validity, the study included only states where Ford had at least 10,000 employees, retirees and dependents enrolled in Ford-sponsored health plans. As shown in Charts 3-6, the states included in the study are Indiana, Kentucky, Michigan, Missouri and Ohio. The Ford study is similar to the GM study in that care was taken to ensure that comparable, reliable multi-state data were analyzed.[6]

Chart 2

General Motors Corporation Health Care Costs
By State and CON Regulation Status
Adjusted Expenditures per Employee*
Percentage Increase, 1996 - 2000

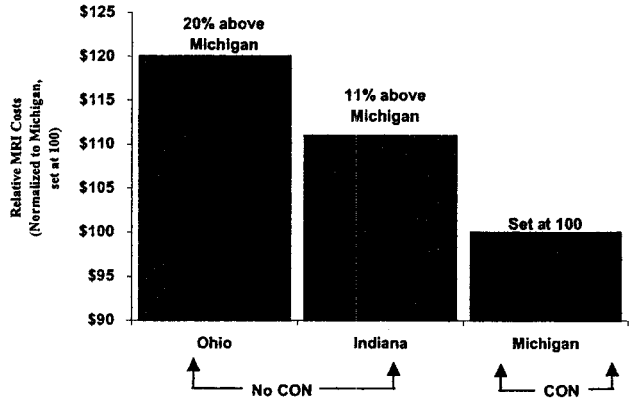


* Includes all hospital, surgical and medical expenses.
** First, and most effective, CON program in the U.S.
Source: General Motors Corporation, *Statement on the Certificate of Need Program in Michigan*, 2002.

In certain respects, the Ford study is broader than the GM study in that it distinguishes inpatient and outpatient hospital costs, as well as service specific costs for MRI scanning and CABG surgery. Where service volumes for a specific service were not sufficient to ensure reliability, the experience in that state was not included in the examination of costs for that service. The Ford study also differs from the GM study in that it is for the year 2000, not a multi-year period. Ford findings were consistent with and complementary to those of GM. Its costs for magnetic resonance imaging (MRI) were substantially higher in Ohio and Indiana than in Michigan. Michigan covers MRI equipment and services under CON; Indiana and Ohio do not regulate MRI services (Chart 3).

Chart 3

Magnetic Resonance Imaging (MRI)
By State and CON Regulation Status
Relative Cost per Service
Cost per 1000 Members Normalized to Michgan, 2000

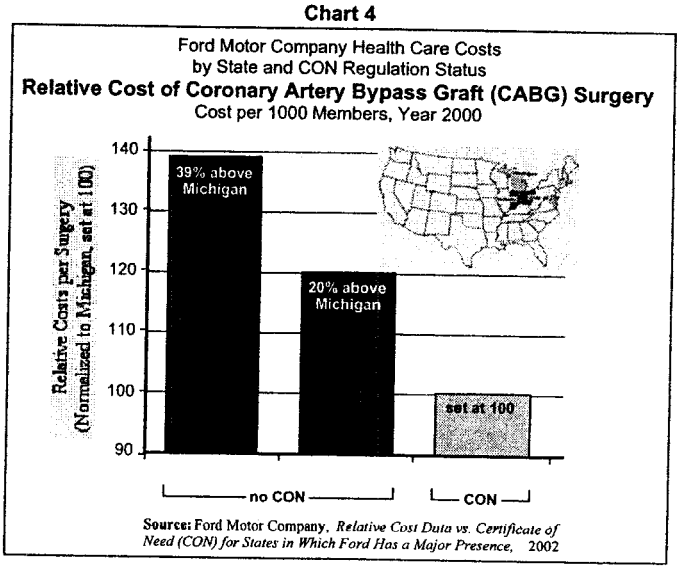


Source: Ford Motor Company, *Relative Costs Data vs. Certificate of Need (CON) for States in which Ford had a Major Presence*, 2002.

Ohio initiated a 3-year phase-out of its CON program in 1995. Magnetic resonance imaging (MRI) is one of the covered services removed from regulation.

This led to a large increase in MRI services and equipment in the late 1990s. Of the three states where there were sufficient data to permit the analysis of MRI services, Ohio had the highest relative costs, 20% above Michigan. Indiana has not had CON coverage of MRI services for nearly two decades. It had the second highest relative costs, 11% above Michigan (Chart 3). Michigan has had a full-coverage CON program since 1972. MRI costs there were the lowest among all states in which Ford Motor has a significant presence and where there were sufficient data to permit statistically significant analysis.

Chart 4

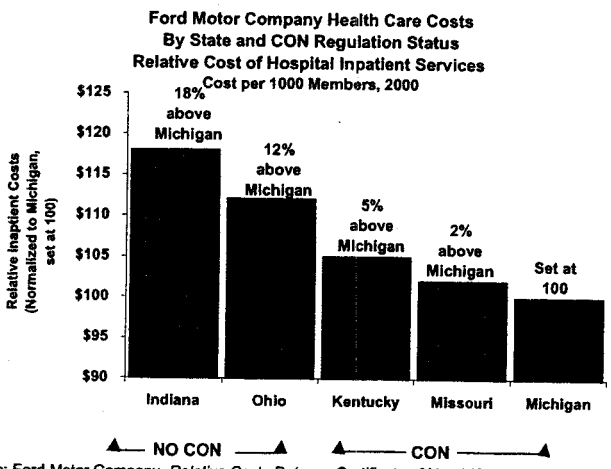


Source: Ford Motor Company, *Relative Cost Data vs. Certificate of Need (CON) for States in Which Ford Has a Major Presence*, 2002

Ford found a similar cost pattern for coronary artery bypass graft (CABG) surgery (Chart 4). Indiana, which has had not had CON regulation of open-heart surgery since the 1980s, had the highest relative costs, 39% above Michigan. As with MRI services, Ohio deregulated open-heart surgery services in 1995. It had the second highest relative costs, 20% above Michigan.

For inpatient hospital costs, Ford found a pattern very similar to that reported by GM. Indiana, with no CON program covering inpatient acute care hospitals since the 1980s, had the highest costs, 18% above Michigan (Chart 5). Ohio, which deregulated most inpatient services in 1995, had the second highest costs, 12% above Michigan's. Kentucky has had a relatively extensive CON program for many years, and its relative in-patient costs were comparatively low, just 5% above Michigan's.

Chart 5

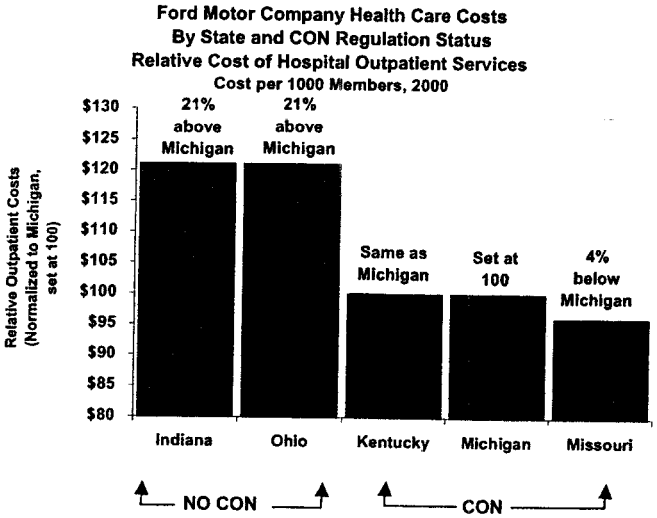


Source: Ford Motor Company, *Relative Costs Data vs. Certificate of Need (CON) for States in which Ford had a Major Presence*, 2002.

Missouri has had a CON program with broad coverage since 1979. It repealed acute care review (except for new hospitals), effective December 2001, but that was after the period covered by this study. Missouri's relative costs were low, just 2% above those of Michigan. Michigan, again, had the lowest costs among the states in which Ford has a significant presence.

The Ford study also examined hospital outpatient services costs (Chart 6). Indiana and Ohio, without CON regulation, had the highest costs, about 21% above Michigan. Michigan's relative outpatient hospital costs were among the lowest of all states.

Chart 6



Source: Ford Motor Company, *Relative Costs Data vs. Certificate of Need (CON) for States in which Ford had a Major Presence*, 2002.

Kentucky's costs were about the same as Michigan's. Missouri's relative costs for outpatient hospital services were the lowest, at 4% below Michigan.

In summarizing its study, Ford emphasized that it is a multi-state corporation with the same benefit plan in all of the states examined, and that the other key factors affecting health care costs are believed to be similar in all of the states studied. Ford also stressed the consistent correlation between CON coverage and lower costs across a wide range of different services and settings. Ford's analysts observed that the failure of academic studies to find the cost benefits of CON regulation Ford documented to the inability of such large imprecise macro econometric studies to account properly and adequately for the many confounding factors that Ford effectively had taken into account.[7]

DaimlerChrysler Corporation

The results of a contemporaneous study by DaimlerChrysler Corporation (DCC) produced similar, complementary results to those reported by Ford and General Motors. DCC emphasized that health care expenses represent a substantial and growing component of its total operating costs. They are now DCC's largest single component cost in producing a vehicle and are rising. Consequently, DCC closely tracks these expenses in each of its major production areas.

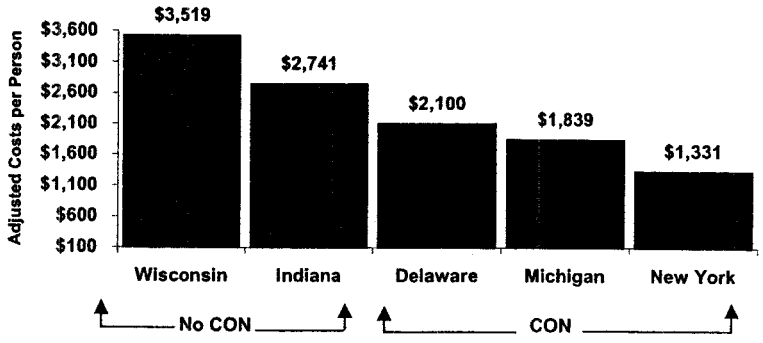
DCC determined that its per-person health care costs are significantly lower in states with CON programs than in states without CON. DCC stressed that its health benefit programs do not vary by geographic region, and that significant differences in relative costs occur between areas even after the data is standardized for gender and age. As found by GM and Fords, DCCs costs for health care are considerably higher in states without CON regulation, such as Wisconsin and Indiana, than in states with CON, such as Delaware, Michigan and New York.

Analysis of health care use and costs in these five states where DCC has a major presence documented that its three lowest-cost regions are in states with CON regulation. By contrast, the two regions with the highest costs are in states without CON regulation (Chart 7). The adjusted per person costs in the southeast Wisconsin (Kenosha area), for example, were more than 2.5 times those in Syracuse, New York.

Although this study was of its own cost experience only, DCC cited and endorsed the experience and views of other business organizations, including the Leapfrog Group, observing that CON regulation also helps ensure quality by assuring minimum and promoting higher average program volumes for many health services.[8]

Chart 7

DaimlerChrysler Corporation Health Care Costs
By State and CON Regulation Status
Adjusted Costs per Person, 2000



Source: DaimlerChrysler Corporation, *Certificate of Need: Endorsement by DaimlerChrysler Corporation*, February, 2002.

Academic and Market Studies

A number of additional studies report that CON regulation has shown positive results in:

- Helping control nursing home capacity and costs,
- Pacing the diffusion of costly new medical technologies and equipment,
- Promoting and assuring quality for a number of acute care services, and
- Maintaining and promoting both geographic and economic access to health care services.[9]

A recent systematic review of studies examining the relationship between service volumes and treatment outcomes identified 72 studies documenting such relationships for more than 20 procedures and diagnoses. Statistically significant relationships between service volume and treatment outcome were found for 11 diagnoses (Exhibit 1) or conditions.[10]

Similar strong relationships were found for another seven conditions, but these did not meet the technical test of statistical significance. Using California as a model, the researchers estimated that several hundred deaths each year are attributable to treatment

in low-volume programs, and that hospital mortality could be reduced significantly if greater effort were made to refer patients to high-volume services.

Exhibit 1
Service Volume and Treatment Outcome
Treatment/Procedures with Inverse Volume-Mortality Relationships

coronary artery bypass graft surgery	cerebral aneurysm
subarachnoid hemorrhage	heart transplantation
pediatric cardiac surgery	liver cancer surgery
elective abdominal aortic aneurysm surgery	carotid endarterectomy
intensive care unit admissions	breast cancer surgery
pancreatic cancer surgery	HIV treatment

R.A. Dudley, et. al., "Selective Referral to High-Volume Hospitals: Estimating Potentially Avoidable Deaths," *JAMA*, Vol. 283 No. 9, March 1, 2000.

The value of high-volume programs, from both an economic and a treatment outcome perspective, has been recognized by many of those responsible for monitoring and purchasing medical care. For example, The Leapfrog Group, an organization sponsored by The Business Roundtable to promote better and more cost-effective medical services, has launched an "evidence-based hospital referral" initiative that seeks to channel high-risk patients to high-volume centers of excellence. It has established volume standards for a number of costly specialized hospital services (Exhibit 2), including a coronary angioplasty (400 or more cases per year) and a coronary artery bypass graft (CABG) surgery (500 or more cases per year).[11]

The importance of program service volumes, and their connection to CON regulation, has been demonstrated recently with the publication of a nationwide study of Medicare patients that documents statistically significant lower mortality rates for CABG surgery patients receiving treatment in programs in states that regulate open-heart surgery under CON. The authors note that most CON studies have focused on whether CON has affected capital investment and health care costs, and few have examined directly the relationship between CON regulation and quality. The study was carefully designed to "compare risk-adjusted mortality and hospital volumes for CABG surgery in states with and without certificate of need regulation."[12]

Exhibit 2
Leapfrog Group
Evidence Based Hospital Referral (EHR) Standards

Treatment/Procedure	***EHR Standard***
Coronary Artery Bypass Surgery	**>500 Volume/Year**
Coronary Angioplasty	**>400 Volume/Year**
Abdominal Aortic Aneurysm Repair	**>30 Volume/ Year**
Carotid Endarterectomy	**>100 Volume/year**
Esophageal Cancer Surgery	**> 7 Volume/Year**

Source: Leapfrog Group, Washington, DC, 2002

The study analyzed the experience of more than 900,000 Medicare patients 65 years of age or older, who underwent CABG surgery in the six-year period between 1994 and 1999. They received care in a total of more than 1,000 US hospitals. States were divided into those with continuous CON regulation (27 states), those that had no CON regulation of open-heart surgery during the study period (18 states), and those that terminated or

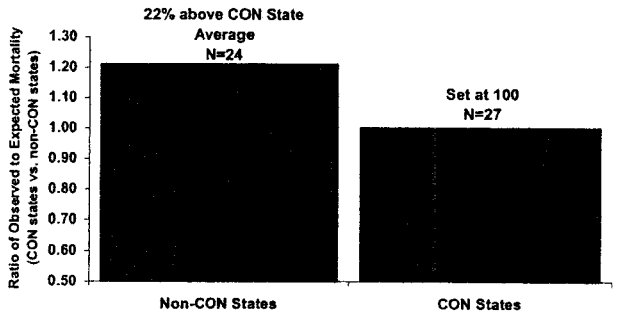
reinstated CON during the period (6 states). The analysis found that risk-adjusted mortality rates were 22% higher in states without CON regulation than in states with regulation. A statistically significant difference was observed in each of the six years of the study period. The study also determined that:

- States with CON regulation had average program volumes 84% higher than those without regulation;
- States that recently terminated CON regulation had large decreases in average CABG surgery volumes; and
- In states without CON regulation, the percentage of patients that had surgery in low volume programs was three times higher than in states with CON regulation.[13]

In addition, the data showed that the repeal of CON regulation resulted in a tripling of the percentage of patients having CABG surgery in low-volume hospitals. This study documents the role of planning and CON regulation in assuring higher average CABG surgery program volumes and the resulting lower risk-adjusted mortality rates.

Chart 8

Cornary Artery Bypass Graft (CABG) Surgery
Risk-Adjusted Mortality by State CON Regulation Status
Medicare Beneficiaries (65 years of age or older)
1994 - 1999



Source: Vaughan-Sarrazin,MS,Hannan,EL,Gormley,CJ,Rosenthal,GE. "Mortality in Medicare Beneficiaries Following Cornary Artery Bypass Graft Surgery in States with and without Certificate fo Need Regulation," *JAMA*, Vol. 288 No. 15, October 16, 2002, *1859 - 1866.*

It is noteworthy that this study also found that a higher percentage of those having CABG surgery in states without CON regulation underwent diagnostic cardiac catheterization or percutaneous transluminal coronary angioplasty (PTCA) on the same day as surgery. This suggests that the treatment outcomes for these procedures may be worse for the same reason that CABG surgery mortality rates are worse in states without CON regulation. The researchers observe "the higher incidence of cardiac catheterization and PTCA on the same day as CABG surgery may reflect higher complication rates for those procedures, rather than greater patient pre-surgical risk."[14]

Critics of CON regulation are reluctant to acknowledge the connection, but there are few mechanisms other than community-based planning and CON regulation that systematically promote regional service programs and minimum patient volumes. These efforts result in better treatment outcomes and lower unit costs. Recognition of this connection, and the abiding value of CON regulation, is the underlying rationale for the recent strong endorsement of CON programs by U.S. automakers.

Taken in combination, the University of Iowa national open-heart surgery study and the automaker's studies present interlocking arguments in favor of CON regulation that are the strongest ever produced. They have a currency and weight that is missing from earlier, and perhaps flawed, econometric studies.

They suggest strongly that states with CON programs benefit substantially from such regulation and related community-based health service planning. The automaker's studies also emphasize that many businesses need health planning and CON regulation to help them attain their goals of providing health insurance coverage, and excellent health care services, to their employees and dependents at an affordable cost.

Suggested FTC-DOJ Focus

Historically, the FTC has tried to assess health care market regulation through standard econometric studies and analyses. These cannot be discounted. They are an important part of any assessment. Though we strongly favor analytical measures and assessments, particularly over the exaggerated anecdotal arguments often heard at public hearings, we do encourage you to take fully into account the broad range of experience and analysis beyond the traditional academic studies. We especially commend the day-to-day experience of the business and labor organizations that have studied their health care markets, as well as the observations and experience of health care providers trying to serve equitably the communities in which they are located. The charts presented above and those in the accompanying PowerPoint presentation present the results of some of these studies.

We caution against accepting uncritically the claims and pleadings of provider organizations that seek economic gain, and market segmentation, under the guise of providing needed competition and greater consumer choice. These special provider pleadings are heard routinely in most states with planning and CON programs. Those seeking to develop highly profitable boutique diagnostic and treatment services, and avoid serving unprofitable and medically indigent persons, often seek special dispensation to do so under these claims.

A high degree of skepticism is in order for organizations that assert that CON is a major barrier to their ability to compete and to prosper. A case on point are the arguments offered by U. S. Oncology, which is rapidly gaining market share and approaching market dominance in many communities. Neither CON regulation nor any other form of community-based planning has been a notable obstacle to the corporation's inexorable march across the country buying local oncology practices as it goes. No state CON program reviews such transactions or in any other way regulates or monitors them. CON regulation and planning come into play only when U.S. Oncology (usually through one of its local subsidiaries or affiliates) seeks to convert purchased medical practices to medical care facilities and acquiring linear accelerators, CT, MRI and PET scanners that divert well insured patients form local hospital cancer programs. Segmentation of the market in this way undermines the ability of essential community hospitals to provide a full array of

oncology services to the entire community. U.S. Oncology and similar organizations seek the benefits of health care facility status, but does not want to have the same rules and regulations applied to them as are applied to service providers.

We believe the expansion and operational activities of organizations that have been identified with questionable billing and other practices in Medicare and other investigations warrant special consideration and examination. The practices of Tenet and HCA in acquiring and divesting community hospitals merit such consideration. So do the acquisition and management practices of U.S. Oncology, which is now being queried about its oncology drug pricing and billing practices by the U.S. House Committee on Energy and Commerce.[15] A broader question worth examining is whether the unusually high prices reportedly offered for oncology practices are being subsidized by inflated drug charges to cancer patients and to the Medicaid and Medicare programs.

Rather than accept the unsubstantiated speculative arguments and assertions of U. S. Oncology and similar special pleaders, FTC should:

- Require that all assertions and claims be documented fully;
- Examine the growth patterns and practices of the corporation, particularly with regard to the methods used to acquire medical practices and the convert those practices to licensed medical care facilities;
- Determine the U.S. Oncology market share for communities where it has a major presence;
- Assess the effects, particularly the economic and quality effects, that the concentration of specialized medical services such as oncology under the control of a national medical services corporation have on local markets and consumers.

Planning and CON agencies may be of some utility in these efforts. Currently, they often are the only entities that:

- Provide a forum where the structure and practices of local health care markets are regularly subject to public examination;
- Promote managed competition, based on price, quality and access, through mechanisms such as requests for proposals (RFPs) and batched competitive review cycles;
- Document and publicize medical trade patterns, including market penetration and share;
- Oppose, and in some cases block, inappropriate hospital mergers, conversions and sales;
- Encourage and otherwise facilitate market entry of competitors where there is evidence of abusive practices;
- Promote equity—the proverbial level playing field—among service providers; and
- Inform the public and other purchasers and consumers of health care services about cost, price, quality and related considerations that make consumers more discriminating.

Areas in which planners and regulators are knowledgeable and where their information and advice may prove useful include:

- **Market Identification & Definition**: Many planners and CON programs have the data and experience needed for determining the size and nature of the market to be examined.

- **Spotting Market Irregularities**: Planners and CON regulators are in unusually good positions to notice market perturbations and other questionable developments early.

- **Monitoring Hospital and Health Plan Conversions and Sales**: Planners are well positioned to examine the effects of tax status conversions, sales and mergers that result in more concentrated local markets and less consumer influence.

Effective community-based planning and targeted regulation that recognize and respond to the realities of health care markets are one of the few means available to identify and cast the light of day on anticompetitive behavior. In health care, planning and focused regulation may be necessary to ensure that the competition that is possible is productive, not destructive.

We invite your attention to and consideration of these questions.

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[1] Antitrust clearance was not granted to a number of nominally not-for-profit foundations established with some of the proceeds from the conversion and sale of not-for-profit hospitals to Columbia-HCA. The foundations established as a result of many of these mergers did not appear to satisfy IRS requirements (Revenue Ruling 98-15) that control indisputably be in not-for-profit entities.

[2] This testimony frequently cross-references the PowerPoint slideshow that was presented in person on June 10,2003. The PowerPoint presentation, titled ***Certificate of Need: Protecting Consumer Interests***, is an integral part of this submission. It is enclosed.

[3] A list of these critical studies is attached, as are lists of studies showing the benefits of service and community based planning and CON regulation and the difference between for-profit and not-for-profit hospital operations.

[4] See General Motors Corporation. *Statement of General Motors Corporation on the Certificate of Need (CON) Program in Michigan*, February 12, 2002.

[5] General Motors Corporation. *Statement of General Motors Corporation on the Certificate of Need (CON) Program in Michigan*

[6] See Ford Motor Company. *Relative Cost Data vs Certificate of Need (CON) for States in Which Ford has a Major Presence*, February 2002. Charts 5-8 are from the Ford report and are used here by permission.

[7] Ford Motor Company. *Relative Cost Data vs Certificate of Need (CON) for States in Which Ford has a Major Presence.*

[8] DaimlerChrysler Corporation. *Certificate of Need: Endorsement by DaimlerChrysler Corporation*, February 2002.

[7] Judith Arnold and Daniel Mendelson, *Certificate of Need: A Synthesis for Policymakers*, Lewin-VHI, March 1993, pp. 10-11

[10] The services and procedures identified include: coronary artery bypass graft surgery, heart transplantation, pediatric cardiac surgery, carotid endarterectomy, pancreatic cancer surgery, cerebral aneurysm, HIV treatment, elective abdominal aortic aneurysm surgery, subarachnoid hemorrhage, liver cancer surgery, breast cancer surgery, intensive care unit admissions, and heart transplantation. See R.A. Dudley, et. al., "Selective Referral to High-Volume Hospitals: Estimating Potentially Avoidable Deaths," *JAMA*, Vol. 283 No. 9, March 1, 2000.

[11] *Evidence-Based Hospital Referral*, The Leapfrog Group, Washington, D C, November 2000 <www.leapfroggroup.org>

[12] 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.*

[13] Vaughan-Sarrazin, MS, Hannan, EL, Gormley, CJ, Rosenthal, GE.

[14] Vaughan-Sarrazin, MS, Hannan, EL, Gormley, CJ, Rosenthal, GE.

[15] See W.J. "Billy" Tauzin and James C. Greenwood, Chairmen, The House Committee on Energy and Commerce, to R. Dale Ross, CEO, U.S. Oncology, June 26, 2003.