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JOHN M. MENDENHALL
Acting Regional Director

March 7, 1988

The Honorable Gerald H. Law
State Representative
House of Representatives
State Capitol Building, Room #220
Lansing, Michigan 48909

Dear Representative Law:

The staff of the Federal Trade Commission[1] is pleased to respond to your invitation to comment on the overall effectiveness of the Certificate of Need ("CON") process and on the report of the Office of Health and Medical Affairs/ Michigan Department of Public Health Certificate of Need Workgroup (the "Workgroup Report"). Although we have not conducted empirical studies that are specific to Michigan, for the reasons discussed in greater detail below we believe that continued CON regulation is unlikely to benefit health care consumers in Michigan. Ongoing improvements in health care financing are resolving the principal problems that prompted CON regulation. Moreover, the benefits of CON regulation, if any, are likely to be outweighed by its adverse effects on competition in health care markets. Consequently, CON regulation is likely to harm consumers on balance by increasing the price of health services in Michigan.

We recognize that the legislature may, for a variety of reasons, choose to retain the CON process. If it does, then certain of the proposals made by the Workgroup could reduce the burden of CON regulation. Other proposals, however, may increase that burden without conferring substantial benefit to Michigan consumers.

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[1] These comments represent the views of the Federal Trade Commission's Bureaus of Competition, Consumer Protection and Economics, and of the Cleveland Regional Office, and not necessarily those of the Commission itself or any individual Commissioner. The Commission has, however, voted to authorize the staff to submit these comments to you.

I. INTEREST AND EXPERIENCE OF THE FEDERAL TRADE COMMISSION.

For more than a decade, the Federal Trade Commission has engaged in extensive efforts to preserve and promote competition in health care markets. The Commission and its staff have been active both in antitrust law enforcement and in advocacy of regulatory reforms. Those efforts are based on the premise that competition in health care service markets, like other markets, will benefit consumers by strengthening incentives for providers to satisfy consumer demands. As a result of Commission antitrust law enforcement efforts and economic analyses of the effects of CON regulation, the Commission's staff has gained experience with the economics of health care competition, and with the ways in which CON regulation affects that competition.[2] Indeed, part of the Commission's antitrust law enforcement effort in the health care field focuses on competitive problems that would not exist, or would be less severe, if there were no CON regulation.[3]

II. CON REGULATION IS INEFFECTIVE AND POSSIBLY COUNTER-PRODUCTIVE IN PROMOTING EFFICIENCY IN HEALTH CARE MARKETS.

A. CON Regulation Is Unnecessary to Remedy Deficiencies in Health Care Reimbursement.

CON regulation of health facilities was introduced principally on the ground that unregulated competition would result in the construction of unnecessary facilities, unnecessary expansion of existing facilities, or unnecessary capital expenditures by health facilities. The assumption underlying this theory was that health facilities had a tendency to expand excessively or purchase unnecessary equipment. Proponents of CON regulation argued that this tendency was not sufficiently constrained by market forces because most consumers of health care were insured by policies that required little or no out-of-pocket payment, making consumers generally insensitive to the price of

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[2] *See, e.g.*, Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. 361 (1985), *aff'd*, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 107 S. Ct. 1975 (1987); Hospital Corp. of America [Forum acquisitions], 106 F.T.C. 298 (1985) (settled by consent order); American Medical Int'l, Inc., 104 F.T.C. 1 (1984); D. Sherman, The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis (1988) (FTC staff report); M. Noether, Competition Among Hospitals (1987) (FTC staff report); K. Anderson & D. Kass, Certificate of Need Regulation of Entry Into Home Health Care (1986) (FTC staff report). Copies of these three FTC staff reports are enclosed with this letter.

[3] *See* Section II.C. below.

health care services.[4] Moreover, health facilities were often reimbursed by third-party payers on a retrospective cost basis, removing whatever incentive they might have had to contain costs.

These forces allegedly generated an incentive for health care facilities to compete on the quality rather than the price of their services, although limited price competition existed. Health care facilities had incentives to expend resources to provide wider ranges of diagnostic and therapeutic services and equipment, and more comfortable facilities.[5] The concern expressed by health planners when CON regulation was created was that the cost of these improved, albeit under-utilized, facilities would be passed along to consumers, thereby increasing the cost of health care. The principal purpose of CON regulation was not to assure that needed facilities would be built when they otherwise would not have been; rather, it was to control the perceived tendency to provide facilities or services that were not needed.[6]

In light of substantial changes in health care markets many of these assumptions underlying arguments in favor of CON regulation appear to have lost their validity. Third-party payers and consumers have shown increasing sensitivity to the prices of hospital services. For example, price competition can be stimulated by health maintenance organizations and preferred provider organizations, which are well-positioned to channel subscribers to hospitals offering quality care at economical rates through selective contracting. Improvements in conventional health benefit programs also provide their subscribers with financial incentives (such as co-payment requirements) that channel them toward economical providers, including nonhospital providers.[7] The increasing sensitivity of health care purchasers to the prices of hospital services limits the ability of hospitals to pass on to consumers the costs of facilities and services that are not useful in meeting consumer demands. There has, accordingly, been a trend toward increased price competition among hospitals.[8]

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[4] *See* Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-99, § 103(b), 93 Stat. 592 (1979), *repealed*, Pub. L. No. 99-960, § 701(a), 100 Stat. 2799 (1986).

[5] *See* Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 478-79; M. Noether, *supra* note 2, at 81.

[6] *See* P. Joskow, Controlling Hospital Costs: The Role of Government Regulation 78-79 (1981).

[7] *See* Insurance Coverage Drives Consumer Prices, *Hospitals*, Nov. 1, 1985, at 91; *see also* W. Manning, *et al.*, Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment, 77 *American Econ. Review* 251 (1987).

[8] *See, e.g.*, Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 480-82; Hospital Industry Price Wars Heat Up, *Hospitals*, Oct. 1, 1985, at 69.

Programs such as Medicare's "prospective reimbursement" system will reinforce this trend.[9] Medicare presently reimburses hospital operating costs at prospective rates which are based principally (and soon exclusively) on flat rates for specific diagnosis-related groups ("DRGs"), rather than the actual costs incurred by a particular hospital for its Medicare patients.[10] As this system, and others like it, are implemented, the costs of any inefficiencies will increasingly come out of the hospitals' own pockets rather than those of third-party payers and individual consumers, providing hospitals the incentive for cost effective provision of service. Indeed, the prospect of future reimbursement reforms is already encouraging greater efficiency on the part of hospitals.[11]

These improvements in hospital markets have been accompanied by similar improvements in other markets currently subject to CON regulation in Michigan. For example, reimbursement of nursing homes in Michigan by Medicaid, an important third-party payer for nursing home services, now provides significant incentives for cost containment, particularly with respect to the construction of new capacity. Capital construction reimbursement is limited to a specific dollar amount per bed.[12] Moreover, the Medicaid program refuses to bear capital and operating costs associated with more than a small amount of unused capacity. These regulations deprive prospective entrants into nursing home markets of any Medicaid incentive to build more capacity than they can reasonably expect to use. It also gives existing firms strong incentives to serve

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[9] *See* J. Robinson, *et al.*, Hospital Competition and Surgical Length of Stay, 239 *Journal of the American Medical Ass'n* 696 at 700 (Feb. 5, 1988) (prospective payment systems counteract the tendency of hospitals to compete for surgeons by allowing the surgeons to hospitalize patients for longer periods).

[10] Medicare plans to begin reimbursing capital costs in a somewhat similar manner. *See* 42 U.S.C.A. § 1395ww(a)(4), (d) (West Supp. 1987); 52 *Fed. Reg.* 18840 (1987) (proposed regulation to phase in flat prospective rates for capital costs over three years for movable equipment, and over ten years for other capital costs); *see also Modern Healthcare*, Aug. 1, 1986, at 20; *Health Care Competition Week*, Jan. 12, 1987, at 4. *But see* Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4006(b)(1), 101 Stat. ___ (1987) (delays implementation of prospective reimbursement for capital-related costs until 1991).

[11] *See* Raske, Association Seeks Sound Capital Pay Policy, *Modern Healthcare*, Nov. 7, 1986, at 120 (uncertainty about future of reimbursement for capital expenses is encouraging hospitals to make more conservative capital investment decisions for inpatient services).

[12] State of Michigan, Medical Assistance Program Bulletin No. 5370-85-02 (1985) § 4.c.

patients more effectively so they can keep their capacity fully utilized.[13] Moreover, price competition for nursing home patients who pay for their care from their own funds[14] deters nursing homes from imposing excessive costs upon those patients. Similarly, price competition and/or well-structured governmental and private reimbursement programs limit incentives for over-investment and other wasteful expenditures for at least some of the other types of health facilities subject to CON regulation in Michigan.[15]

B. CON Regulation Is Ineffective as a Cost-Containment Mechanism.

It is not clear that CON regulation has had the intended effect of containing health care costs. A number of empirical studies suggest that CON regulation has not controlled general acute care hospital costs by preventing expenditures for unnecessary beds, services, and equipment.[16] Early studies of the effects of CON regulation found that instead of constraining overall hospital costs, it may have simply caused hospitals to reallocate their resources. Thus,

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[13] As we understand it, Michigan Medicaid computes capital and operating cost reimbursement per Medicaid patient day, in most instances, by dividing a nursing home's allowable costs by the number of patient days per year the nursing home would have had if it operated at an 85 percent occupancy rate (or, if greater, the actual number of patient days). As a result, Medicaid pays only costs allocated to the capacity used by its beneficiaries, except that it bears some of the costs of unused capacity not exceeding 15 percent of total capacity. State of Michigan, Reimbursement for Skilled Nursing & Intermediate Care Facilities (1982) at II-5. Other states, such as Virginia, bear the cost of unused capacity only up to 5 percent.

[14] *See* A. Lee, H. Birnbaum & C. Bishop, How Nursing Homes Behave: A Multi-Equation Model of Nursing Home Behavior, 17 *Social Science and Medicine* 1897, 1905 (1983) (private patient demand for individual nursing homes' services is price elastic).

[15] *See, e.g.*, 52 *Fed. Reg.* 20466 (1987), 52 *Fed. Reg.* 20623 (1987) (Medicare reimburses freestanding ambulatory surgery centers at flat prospective rates, and will soon provide half the reimbursement for hospital outpatient surgery on the same basis (with the other half cost-based)).

[16] A 1986 FTC staff report reached a similar conclusion about the effect of CON regulation on home health care services. K. Anderson & D. Kass, *supra* note 2, at 87-92 (1986). A study of the economic behavior of nursing homes, which did not focus on the effectiveness of CON regulation, noted that CON regulation appeared to increase, rather than decrease, the average cost of nursing home services. A. Lee, H. Birnbaum & C. Bishop, How Nursing Homes Behave: A Multi-Equation Model of Nursing Home Behavior, *17 Social Science and Medicine* 1897 at 1906 (1983).

while some types of hospital costs were constrained by CON regulation, other costs increased.[17] Later studies reached similar conclusions, finding that CON regulation did not reduce costs per unit of hospital output.[18] Finally, several studies including two recent FTC staff reports, concluded that the adoption and maintenance of CON regulation is associated with increases in hospital costs.[19] These studies suggest that, as a means of cost containment, CON laws may be at best ineffective and at worst cost increasing.

A 1987 evaluation of the effect of Michigan's CON program on cost containment acknowledged that opinion is divided on the subject of the effectiveness of CON programs in containing costs, but concluded that Michigan's CON program had deterred unneeded projects.[20] This conclusion was based on the increased volume of denied CON applications from 1979 through 1985 and anecdotal evidence that negotiations between applicants and agency staff had reduced the cost of proposed projects.[21] The same evaluation expressed concern about the amount of construction that would take place, particularly in nursing homes, if CON were repealed.[22]

However, the dollar amount of projects denied, withdrawn or modified as a result of the CON process does not necessarily represent a savings in the overall cost of health care nor does it necessarily represent an accurate

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[17] Salkever & Bice, Hospital Certificate-of-Need Controls: Impact on Investment, Cost, and Use (1979); Salkever & Bice, The Impact of Certificate-of-Need Controls on Hospital Investment, *54 Milbank Memorial Fund Q.* 185 (Spring 1976).

[18] Policy Analysis, Inc.–Urban Systems Engineering, Inc., Evaluation of the Effects of Certificate of Need Programs (1980); Steinwald & Sloan, Regulatory Approaches to Hospital Cost Containment: A Synthesis of the Empirical Evidence, in A New Approach to the Economics of Health Care, American Enterprise Institute (1981).

[19] D. Sherman, *supra* note 2, at iv, 78; and M. Noether, *supra* note 2, at 74, 82; used cross-section data. F. Sloan and B. Steinwald, Effects of Regulation on Hospital Costs and Input Use, *23 Journal of Law and Economics 81* (1980) and C. Coelen and D. Sullivan An Analysis of the Effects of Prospective Reimbursement on Hospital Expenditures, *3 Health Care Financing Review 1* (1981), used pooled cross-section time-series data. *See also* Anderson & Kass, *supra* note 2, at 87-92 (CON does not decrease, and may increase, the costs of home health care agencies).

[20] Michigan Statewide Health Coordinating Council, An Evaluation of the Certificate of Need Program, March 19, 1987 (hereinafter "SHCC Evaluation") at 11-14.

[21] *Id.*

[22] *Id.* at 8-9.

measure of the amount of "excessive" capital investment deterred. The existence of CON regulation forces firms to compete for a limited number of certificates of need.[23] The CON process also provides incentives for such activities as the filing of pre-emptive applications and nuisance applications.[24] Thus, to presume that all projects applied for would be built in the absence of CON regulation and that the dollar amount of applications denied, modified or withdrawn represents actual deterrence is probably incorrect. Furthermore, deterrence of capital spending by CON regulation may not yield an overall savings in health care costs since costs may increase in other areas not covered by CON regulation, as suggested by some of the studies mentioned above.[25]

Concern that unnecessary capital spending will occur if CON regulation is repealed is based on early reports of the experience of Arizona and Utah with CON repeal.[26] However, one detailed analysis of the post-CON events in these states shows that most increases in construction that did occur were likely to be short-term and in areas which were under-served.[27] For example, Arizona's "surge" in nursing home construction began even before CON expired – when its bed-to-population ratio was the lowest in the nation and substantially below the national average – and continued during a period when the State experienced substantial in-migration of aged persons.[28] Also, an initial study of

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[23] This is particularly true where applications are subject to comparative review. Even for applications not subject to comparative review, however, since the burden is on the applicant to demonstrate need, applicants will ordinarily assume that any CON granted reduces the likelihood that a similar CON will be granted to another applicant. This generates pressure to file pre-emptively or defensively.

[24] SHCC Evaluation at 32. (It has been alleged that applications are made for the purpose of protecting the applicant's long-term interest – without any present intention to offer the service – or to obstruct potential competitors.)

[25] *See* sources cited *supra* notes 17 and 18 and Anderson & Kass, *supra* note 2, at 87-92; *See also*, C. Havighurst, Regulation of Health Facilities and Services by "Certificate of Need," 59 *Virginia L. Rev.* 1143, 1218 (1973).

[26] SHCC Evaluation at 8-9. While we argue in this paragraph that predictions of increased hospital and nursing home construction are overstated, it should not be inferred that we consider such construction to be undesirable. As we have discussed in previous sections, CON regulation restricts supply, so it is expected that construction will occur where supply has not kept pace with demand. On the other hand, if there is an over-supply in a particular area (*e.g.*, acute care hospital beds) new construction is unlikely to occur.

[27] M. Lerner, *et al.*, Investigation of Certain Issues in Connection With the Virginia Certificate of Need Law, at VI, 9-17, 27-40; VII, 5-7 (final report, August 10, 1987) (hereinafter "Johns Hopkins Report").

[28] *Id.* at VII, 12, 27.

the effects of CON repeal in Arizona reported a strong surge in applications for hospital projects. A later study found, however, that much of the planned construction did not materialize.[29] The Johns Hopkins Report found that Utah experienced an increase, but not a "surge" in nursing home construction, while new hospital construction was limited to freestanding psychiatric hospitals.[30] The Report concluded that the change to a prospective payment system by Medicare had diminished the incentives toward new capital investment by hospitals.[31]

C. CON Regulation Interferes with Competition in Health Care Markets.

CON regulation, on balance, may be not only ineffective but actually counterproductive in the control of health care costs. As discussed below, the CON regulatory process itself imposes substantial costs on applicants, in terms

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[29] Results of both studies are summarized, *Id.* at VII, 5. Arizona did experience substantial growth in the number of open-heart surgery units, but other states that repealed CON did not. *Id.* at VII, 10.

[30] *Id.* at VI, 12-13, 16.

[31] *Id.* at VI, 14-16. The experience of Arizona, Utah, Kansas and Texas is summarized at VII, 5-6. The Report concludes that "indications from these four states are that substantial growth in hospital beds is unlikely on CON sunset." *Id.* at VII, 6.

Just as Medicare is influencing capital investment decisions by hospitals, state Medicaid reimbursement policies are an important influence on the growth of nursing homes. *Id.* at VI, 13-14 and VII, 14-15 (states with very high occupancy ratios can expect an increase in construction or conversion of beds upon CON repeal, but the level of Medicaid reimbursement is an important influence on the amount of growth, along with other factors, such as the existing bed-to-population ratio and the geographic distribution of existing beds). Michigan already has in place some Medicaid reimbursement policies that should deter unnecessary nursing home construction in the event of CON repeal. Current regulations impose a cap on reimbursement for capital costs for new long-term-care beds which is well under the actual capital cost of construction. *See* Workgroup Report, Attachment C-4, Position Statement of Health Care Association of Michigan. Since operating-cost reimbursement levels are at actual cost, there is no incentive to build unnecessarily. To further discourage new construction, the occupancy rate necessary to obtain full-cost reimbursement for unused capacity (*supra* note 13) could be raised from 85 percent to 90 percent, or even 95 percent.

of both the effort required to obtain regulatory approval and the delays occasioned by the regulatory process. To the extent that CON regulation reduces the supply of particular health services below competitive levels, their prices can be expected to be higher than they would be in an unregulated market.[32] Curtailment of available services or facilities may create shortages which force consumers to resort to more expensive or otherwise less desirable substitutes, thus increasing costs for third-party payers and/or patients. For example, a shortage of nursing home beds can delay the discharge of patients from more expensive general acute care hospital beds[33] or force patients to use nursing homes far from home.

Even if it does not yield acute shortages of services, CON regulation can substantially interfere with competition in health care markets. First, the CON regulatory process may increase prices to consumers by protecting firms in the market from competition from innovators and new entrants.[34] Although the CON process does not always prohibit the entry or expansion of health facility enterprises, or the development of new services, it generally places the burden on new entrants to demonstrate that a need is not being served by those currently in the market. In addition, the process of preparing and defending a CON application is often extremely costly and time consuming (particularly if the application is opposed by firms already in the market).[35] CON regulation may also create opportunities for existing firms to abuse the regulatory process

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[32] Where prices are regulated, the "price increase" may take the form of reductions in service quality, so that consumers receive services of lesser value for the same price, instead of paying more money for the same services.

Severe shortages of capacity can protect firms providing substandard service to consumers not only from competitive pressures to upgrade performance, but also from regulatory pressures to adhere to licensure requirements. For example, a state agency may be reluctant to close a nursing home for major violations of licensure requirements if the patients cannot be placed elsewhere. *See* J. Feder & W. Scanlon, Regulating the Bed Supply in Nursing Homes, *58 Milbank Memorial Fund Q.* 54, 76 (1980).

[33] U.S. General Accounting Office, Constraining Health Care Expenditures: Achieving Quality Care at Affordable Cost, at 93-94 (1985).

[34] Posner, Certificate of Need for Health Care Facilities: A Dissenting View, in Regulating Health Facility Construction at 113 (C. Havighurst, ed. 1974); M. Noether, *supra* note 2, at 82 (CON restrictions on entry associated with hospital price increases of approximately 4 to 5 percent, as well as increases in hospital costs of approximately 3 to 4 percent).

[35] SHCC Evaluation at 29-34. (Number and complexity of CON appeals increased dramatically from 1979 to 1986. Comparative reviews are particularly protracted.) *See also* Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 490-92.

so as further to prevent or delay new competition.[36] CON regulation, therefore, makes entry and expansion less likely, or at least less rapid. Firms in any given market need not be as competitive in price or as sensitive to consumer demand for new services if they know that it will be difficult and expensive for new firms to enter the market and offer competitive prices or services.

Second, by reducing the likelihood of (or at least increasing the cost and time required for) entry and expansion, CON regulation can make it more likely that providers will exploit whatever market power they have, individually or collectively, to raise prices above (or reduce quality below) the competitive level.[37] That is why, in both of the hospital merger decisions issued by the Federal Trade Commission in litigated cases, the Commission cited the entry barrier created by CON regulation as a factor significantly contributing to the potential for anti-competitive effects from the mergers.[38] CON regulation can thus render anti-competitive otherwise lawful conduct, and aggravate the anti-competitive effects of antitrust violations.[39]

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[36] T. Calvani & N. Averitt, The Federal Trade Commission and Competition in the Delivery of Health Care, 17 *Cumberland L. Rev.* 293, 298-99 (1987) (discussing potential for health providers to use CON process for "non-price predation"); St. Joseph's Hospital v. Hospital Corp. of America, 795 F.2d 948, 959 (11th Cir. 1986) (defendants' misrepresentations to state health planning body concerning plaintiff's CON application not protected from antitrust scrutiny); Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 492.

[37] This is most likely to occur where there are few competing providers in a particular market, *see* Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 487-89, such as in rural areas, or for certain hospital specialty services.

[38] American Medical Int'l, Inc., 104 F.T.C. at 200-01 (1984); Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 489-496.

[39] In particular, the entry barriers created by CON regulation can transform into possible antitrust violations potentially efficient joint activities by health care providers that would otherwise be lawful. For example, in some cases shared service arrangements and consolidations could significantly threaten competition, unless the prospect of new entry would keep the market competitive by making any significant, sustained price increases unprofitable. CON regulation can thus conflict with the achievement of health planning objectives by limiting the freedom of providers to realize efficiencies without creating unacceptable risks of anti-competitive effects.

D. CON Regulation Is Not a Good Mechanism for Addressing Concerns Related to Access for Indigent Patients.

It has been proposed that the CON process in Michigan be extended to deal specifically with problems of access to the health care system for indigent patients.[40] In our view, CON regulation may be a poor method for addressing the issue of access, so that concerns for access may not justify its retention.

CON regulation might serve as a means of ensuring access to health care in two related ways. First, CON regulation may enable the State to steer health care capital expenditures to under-served and "economically disadvantaged regions" (defined as areas with a substantial percentage of indigent households).[41] Second, providers who serve indigent patients and subsidize care for them through revenues from paying patients can be protected against the establishment or expansion of other providers who would draw off the paying patients without serving indigent patients.[42]

Insulation from competition is the inducement offered to providers in order to encourage them to locate facilities near indigent populations and to provide care for indigent patients without full reimbursement. However, this insulation itself imposes substantial costs on the health care system, resulting in higher prices and, possibly, lower quality as well.[43] Moreover, this method of funding access may be less equitable than direct taxation. CON regulation, in effect, imposes a "hidden tax" on all consumers of health services in the form of higher prices and lower quality. That "tax" may be more costly to society than conventional forms of taxation because of its interference with health facility competition; moreover, the burden of that "tax" falls disproportionately on those in poor health.[44] In fact, other ways of funding care for the indigent are available which do not restrain competition.[45]

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[40] SHCC Evaluation at 1-2; Workgroup Report at 7.

[41] SHCC Evaluation at 20-21.

[42] SHCC Evaluation at 21-22 (proposal to give "preference" in CON proceedings to facilities which serve indigent populations).

[43] *See* p. 9, *supra*, note 32 and accompanying text.

[44] *See* R. Posner, Taxation by Regulation, 2 *Bell J. of Econ.* 22 (1971); C. Havighurst, *supra*, note 25 at 1188-94 (1973).

[45] The Johns Hopkins Report contains a brief summary of methods used in various states to fund hospital care for the indigent. *Id.* at VII, 23-24, citing "Review's 1986 State-by-State Survey: A Special Report," *FAHS Review*, Sept./ Oct. 1986, at 27-42.

III. IF THE CON PROCESS IS RETAINED, THE THRESHOLDS SHOULD BE RAISED, AND THE SCOPE OF COVERAGE SHOULD BE RESTRICTED, IN ORDER TO REDUCE THE NEGATIVE EFFECTS OF CON ON THE COMPETITIVE PROCESS.

Michigan's current thresholds for CON coverage – $150,000 for capital expenditures including major medical equipment, and zero for new institutional services – are the lowest in the nation. The Workgroup proposal would increase the threshold for capital expenditures to $750,000.[46] It is anticipated that the increase in the threshold for capital expenditures to $750,000 could eliminate 50 percent of the applications.[47] In practice, even this benefit is not certain because some CON applications with capital expenditures below the threshold would be covered as new services or under other provisions of the CON law.[48] Several states have increased their thresholds to considerably higher figures. The Michigan Senate has passed a bill that would raise the threshold for capital expenditures to $1.5 million with annual indexing to allow future increases.[49] A 1988 report by the FTC's Bureau of Economics found that hospitals in states with higher CON thresholds actually have lower overall costs.[50]

The Workgroup proposes to broaden coverage of major medical equipment by listing covered equipment specifically, and subjecting it to CON coverage regardless of where it is located.[51] Thus, equipment would be covered if located either in a hospital or in a doctor's office. The reason given for broadening CON coverage of major medical equipment purchases is to make CON coverage more equitable.[52] However, the facial appearance of inequity may not be a reality. Even if the legislature decides that hospitals still have incentives to make unnecessary capital investments,[53] and therefore continues CON review of their capital investments, physicians' groups and other providers not reimbursed on a retrospective-cost basis for capital expenditures may have no such incentives. Thus, CON review of their proposed expenditures offers little prospect of public benefit while imposing costs both on the providers (complying

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[46] Workgroup Report at 4, 6.

[47] SHCC Evaluation at 14-15.

[48] *Id.*

[49] Senate Bill No. 64, Section 1 (March 31, 1987).

[50] D. Sherman, *supra* note 2, at vi, 7, 59-60, 78.

[51] Workgroup Report at 4.

[52] *Id.*; SHCC Evaluation at 16.

[53] We disagree with this proposition (see Section II.A., *supra*).

with the process) and the public (administering it and being unable to benefit from the new technology while the CON review is underway).

The Workgroup recommendations also propose to delete certain types of facilities from coverage by CON.[54] The deletion of these facilities should encourage competition and innovation in these areas of health care. Since many of the facilities to be deleted from CON coverage represent less costly alternatives to inpatient care, competition and innovation in these areas will contribute to cost containment in health care generally.[55] A staff report by the Commission's Bureau of Economics has concluded that CON regulation of entry into one of these areas - home health care - did not result in lower costs, and may have increased costs while imposing administrative costs and restricting entry.[56] Indeed, the legislature may wish to consider additional facilities for deletion from CON regulation.[57]

The Workgroup did not recommend a change in the threshold for new institutional services offered by covered facilities, leaving it at zero.[58] Thus, a new clinical health service offered by a facility subject to CON regulations

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[54] These are: homes for the aged, organized ambulatory care facilities, home health care facilities, facilities operated by the Michigan Department of Mental Health, outpatient physical therapy facilities, tertiary health care service facilities, substance abuse treatment programs, outpatient psychiatric clinics, and clinical laboratories. Workgroup Report at 2.

[55] CON regulations tend to raise the price of medical services by limiting their availability. *See* Ermann & Gabel, The Changing Face of American Health Care, *Medical Care*, 1985, at 407.

[56] Anderson & Kass, *supra* note 2.

[57] For example, the Workgroup Report proposes to continue CON coverage for freestanding surgical outpatient facilities. Workgroup Report at 1. However, the evidence suggests that growth of such facilities, which in many cases are an innovative, less costly alternative to inpatient surgery, has been hampered by the CON process. *See* Ermann & Gabel, *supra*, note 60. It is particularly in such areas of innovation that CON regulation has been shown to be counterproductive to cost containment. *See, e.g.*, Anderson & Kass, *supra* note 2. In addition, it is difficult to predict demand for ambulatory surgery because it is rapidly becoming more accessible due to improvements in technology and greater acceptance by physicians. While state health-planning agencies might provide information or guidance on future trends, firms have incentives to gather their own information and to adjust rapidly to unexpected changes in trends. The need to meet CON requirements may delay adjustments in this rapidly growing and changing market. For these reasons, reliance on market forces, rather than CON regulation, is likely to provide greater flexibility in adapting to changing conditions.

[58] Workgroup Report at 3-5.

would be covered regardless of its capital or operating costs. This restriction on the activities of covered facilities may reduce the benefits which would otherwise be obtained by raising thresholds for CON coverage of capital expenditures and by deleting many types of facilities from coverage (depending on how the term "clinical health service" is defined). We urge the legislature to evaluate carefully whether this restriction is necessary in light of the changes in the health care marketplace described earlier in this letter.

IV. CONCLUSION.

We believe that the continued existence of CON regulation would be contrary to the interests of health care consumers in Michigan. Ongoing changes in the health care financing system, including prospective payment mechanisms and increased consumer price sensitivity fostered by private insurers, are eliminating the principal problem that prompted CON regulation. Moreover, the CON regulatory process does not appear to serve its intended purpose of controlling health care costs. Indeed, it may defeat that purpose by interfering with competitive market forces that would otherwise help contain costs. However, should the legislature decide to retain CON regulation, then decreases in coverage and increases in the threshold for covered services may reduce the negative effects of the CON system.

We would be happy to answer any questions you may have regarding these comments, and to provide any other assistance you may find helpful.

Sincerely yours,

John M. Mendenhall
Acting Director
Cleveland Regional Office

Enclosed FTC Staff Reports:

The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis (1988);

Competition Among Hospitals (1987); and

Certificate of Need Regulation of Entry Into Home Health Care (1986).