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UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
ATLANTA REGIONAL OFFICE

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COMMISSION AUTHORIZED

March 4, 1988

The Honorable Culver Kidd
Room 453
State Capitol
Atlanta, Georgia 30334

Dear Senator Kidd:

The staff of the Federal Trade Commission[1] is pleased to comment on Senate Bill 398 ("S.B.398"). If enacted, the bill would exempt from the requirements of Georgia's Certificate of Need ("CON") process for a period of one year the offering by "health care facilities" of new "clinical health services" that do not result in the addition of new hospital beds.[2] It would not, however, exempt from the CON process either home health care

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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 Atlanta 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.

[2] For CON purposes, the Georgia Code, § 31-6-2(5), defines "Clinical Health Services" to mean: "diagnostic, treatment, or rehabilitative services provided in a health care facility, or parts of the physical plants where such health services are located in a health care facility, and includes, but is not limited to, radiology; radiation therapy; surgery; intensive care; coronary care; pediatrics; gynecology; obstetrics; dialysis; general medical care; medical/surgical care; inpatient nursing care, whether intermediate, skilled, or extended care; cardiac catherization; open-heart surgery; inpatient rehabilitation; and alcohol, drug abuse, and mental health services."

A "Health Care Facility" is defined in § 31-6-2(8) as: hospitals; other special care units, including podiatric facilities, skilled nursing facilities, and kidney disease treatment centers, including freestanding hemodialysis units; intermediate care facilities; personal care homes not in existence on the effective date of this chapter; ambulatory surgical or obstetrical facilities; health maintenance organizations; and home health agencies."

intermediate, skilled, or extended inpatient nursing care. Moreover, the bill provides that the capital costs expended to initiate the clinical health services that it does exempt "shall not be reimbursed by the Department of Medical Assistance under the Medicaid prospective payment system."

Although we have not made a study of the effects of CON regulation in Georgia,[3] we believe that Georgia's CON regulatory process may not benefit health care consumers for the reasons discussed below. 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. As a result, CON regulation may have a negative effect, increasing the price and decreasing the quality of health services in Georgia.

We will focus our comments on the general ineffectiveness of CON laws in promoting the welfare of health care consumers. Although S.B. 398 would relax Georgia's CON requirements only to a limited extent, passage of the bill, in our view, represents a worthwhile undertaking, which may lead to greater diversity and better quality in health care services and increased price competition in the health care market. Success of S.B. 398 would provide incentives for further reductions in Georgia's "need" based regulation of health care.

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,

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3 One of the areas with respect to which you have indicated an interest in our comments is the effect of CON regulation on the provision of health care facilities and services in rural areas of Georgia. As stated in the text, we have not made a study of CON regulation in Georgia. Consequently, we are not in a position to make any statements about the relative impact of CON regulation on rural and urban areas of the state. Nor are we aware of any discussion of this issue in the economic literature dealing with CON regulation generally. This is not to say, of course, that such regulation may not have a disproportionately adverse effect on rural areas.

benefits consumers by strengthening incentives for providers to satisfy the demands of health care consumers. As a result of economic analyses of the effects of CON regulation, the Commission's staff has gained considerable experience with the economics of health care competition and with how CON regulation effects that competition.[4] In addition, 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 regulations.[5]

II. CON REGULATION IS INEFFECTIVE, AND PROBABLY COUNTER-PRODUCTIVE, IN PROMOTING THE EFFICIENT PROVISION OF HEALTH CARE SERVICES

A. CON Regulation Is Unnecessary to Constrain Health Care Costs.

The traditional justification advanced in favor of CON regulation of health care has been that unregulated competition would result in the unnecessary construction or expansion of facilities or in other unnecessary capital expenditures. The assumption underlying this theory is that health care providers have a tendency to expand their facilities or purchase equipment excessively. CON advocates contended that this tendency was not sufficiently constrained by market forces because many health care consumers were covered by insurance policies issued by third-party payers requiring little or no out-of-pocket payment for health care services. Consumers were therefore thought to be insensitive to price differences among providers, thus insulating providers from price competition. Moreover, health care providers were often reimbursed by third-party payers on a retrospective cost basis, which provides little incentive to contain costs.

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[4] See, e.g., Sherman, The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis (1988) (FTC staff report); Noether, Competition Among Hospitals (1987) (FTC staff report); and Anderson & Kass, Certificate of Need Regulation of Entry Into Home Health Care (1986) (FTC staff report).

[5] See, e.g., Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. 361, 489-96 (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); and American Medical Int'l, Inc., 104 F.T.C. 1 (1984).

To the extent that these contentions were accurate, health care providers would have had incentives to compete primarily in terms of quality rather than price, although limited price competition existed.[6] Providers had an incentive to compete for patients and physicians by offering wider ranges of diagnostic and therapeutic services and equipment and more comfortable facilities, even if the new facilities were underutilized. The initial concern expressed by the proponents of health care planning was that these expenditures would increase overall health care costs and be passed along to the public through hospital charges, insurance premiums, and taxes (to support, e.g., Medicare and Medicaid). Thus, the primary purpose of CON regulation was not to assure that facilities were placed where needed; rather, it was to control the perceived tendency to unnecessarily increase health care costs by providing duplicative facilities or services.[7]

As a result of significant changes in health care markets in recent years, many of the assumptions underlying the arguments offered in favor of CON regulation are probably no longer valid.[8] There has been a trend toward increased competition, particularly price competition, among health care providers.[9] Third-party payers and consumers are no longer insensitive to the prices of health care services. Conventional health benefit programs now generally provide subscribers with financial incentives (such as co-payments) to patronize more economical providers, including non-hospital providers.[10] In addition, health maintenance organizations and preferred provider organizations tend to channel

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6 See, Hospital Corp. of America, 106 F.T.C. at 478-79.

7 See P. Joskow, Controlling Hospital Costs: The Role of Government Regulation (1981).

8 Indeed, the United States Congress recently repealed the National Health Planning and Resources Development Act of 1974, which had provided incentives and penalties to encourage states to enact CON regulations. See P.L. 99-660, § 701 (1986).

9 See, e.g., Hospital Corp. of America, 106 F.T.C. at 480-82; Hospital Industry Price Wars Heat Up, Hospitals, Oct. 1, 1985, at 69; Noether, supra note 4, at 81-89.

10 See Manning, Newhouse, Liebowitz, Duan, Keeler, & Marquis, Health Insurance and the Demand for Medical Care, 77 American Economic Review 251, 267-68 (June 1987); Insurance Coverage Drives Consumer Prices, Hospitals, Nov. 1, 1985, at 91.

subscribers to health care providers offering lower rates. The increasing sensitivity of both individual and institutional 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.

Programs such as Medicare's "prospective reimbursement" system reinforce this trend.[11] Medicare presently reimburses hospital operating costs at prospective rates that are based principally (and soon will be based exclusively) on flat rates for specific diagnosis related groups (DRGs) rather than the actual costs incurred by a particular hospital for its Medicare patients[12]. As this reimbursement system is implemented, the costs of a hospital's inefficiencies may increasingly be borne by that hospital, thus creating incentives for more cost-effective provision of hospital services. Indeed, the prospect of future reimbursement reforms is already encouraging greater efficiency on the part of hospitals.[13]

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11 See Robinson, et al, Hospital Competition and Surgical Length of Stay, 239 Journal of the American Medical Ass'n 696, 700 (1988) (prospective payment systems counteract the tendencies of hospitals to compete for surgeons by allowing the surgeons' patients to increase the length of their hospital stays).

12 Medicare had planned to begin reimbursing hospital 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. However, the recent budget compromise in Congress included a four-year moratorium on implementation of prospective rates for reimbursement of capital costs. See Modern Healthcare, Dec. 18, 1987, at 45.

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

B. CON Regulation Has Been Ineffective as a Cost-Containment Mechanism.

A number of empirical studies suggest that CON regulation has not controlled general acute care hospital costs by preventing expenditures on unnecessary beds, services, and equipment.[14] Early studies of the effects of CON regulation found that it had no effect on constraining overall hospital costs; rather, it may have simply caused hospitals to reallocate their resources so that, while some types of hospital costs were constrained by CON regulation, other costs increased.[15] Later studies reached similar conclusions, finding that CON regulation did not reduce

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[14] A 1986 FTC staff report reached a similar conclusion about the effect of CON regulation on home health care services. Anderson & Kass, supra note 4, at 87-92 (1986). A study of the economic behavior of nursing homes, which did not focus on the effectiveness of CON regulation, found evidence that CON regulation increases, rather than decreases, the average cost of nursing home services. Lee, Birnbaum & Bishop, How Nursing Homes Behave: A Multi-Equation Model of Nursing Home Behavior, 17 Social Science and Medicine 1897, 1906 (1983).

[15] 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).

It is true, of course, that if the CON process significantly reduces the level of capital investment in hospitals, equipment, and other assets below the level that would otherwise obtain, total health care costs attributable to these factors will be less. Whether this is desirable, however, depends on the extent to which the reduction in the output of particular health care services due to the CON-imposed constraint advances the regulation's proffered justification -- the curtailment of capital investments that are financially feasible only if costs can be shifted to third-party payers. If additional investment is curtailed, then some health care services for which consumers would have been willing to pay more than is necessary to cover all of the capital and other attendant costs of providing them will nonetheless not be supplied. In addition, the prices of each of the particular services whose supply is curtailed by the regulation will rise above competitive levels.

costs per unit of hospital output.[16] Finally, studies using both cross-section and time-series data have shown that the adoption and maintenance of CON regulation is associated with higher levels of hospital costs.[17] These studies suggest that, as a means of "cost containment," CON laws may be at best ineffective and at worst cost increasing.

C. CON Regulation Interferes With Competition and Innovation in Health Care Markets

On balance, CON regulation may not be merely ineffective but actually counterproductive in its contribution to the control of health care costs. As discussed below, the CON regulatory process itself imposes substantial costs on applicants in terms of both the effort required to obtain regulatory approval and the delays occasioned by the regulatory process. Moreover, 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.[18] Curtailment

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[16] 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).

[17] See Sherman, supra note 4; Noether, supra note 4; Coelen & Sullivan, An Analysis of the Effects of Prospective Reimbursement on Hospital Expenditures, Health Care Financing Review, 3 (Winter 1981), 1-40; and Sloan & Steinwald, Effects of Regulation on Hospital Costs and Input Use, Journal of Law and Economics 23 (1980), 81-109. Sloan & Steinwald and Coelen & Sullivan obtained this result using pooled cross-section and time-series data. Noether and Sherman used cross-section data.

[18] 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. When severe shortages of capacity exist, firms providing substandard service to consumers may be protected 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.

of available services or facilities may create shortages that force consumers to resort to more expensive or otherwise less desirable substitutes for the appropriate form of health care, 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[19] or force patients to use nursing homes far from home.

Even if CON regulation does not yield acute shortages of services, it can substantially interfere with competition in health care markets. First, the CON regulatory process can increase prices to consumers by protecting firms in the market from competition by innovators and new entrants.[20] 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. Because the views of CON regulators may be influenced by factors in addition to consumer demand,[21] the CON process may reduce the possibility of entry by more efficient firms that could provide higher quality and/or lower cost services and, possibly, replace less efficient providers.

See Feder & Scanlon, Regulating the Bed Supply in Nursing Homes, 58 Milbank Memorial Fund Q. 54, 76 (1980).

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

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

21 Georgia Code § 31-6-42, dealing with "Qualifications for issue of certificate," is a good example of this. In addition to consumer "need," the planning agency takes into account such factors as whether in its view existing facilities are adequate for providing a proposed health service, whether a proposed project is deemed adequately financed, a project's likely effect on third-party payers, and whether a proposed health facility would conduct bio-medical research.

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).[22] CON regulation can also create opportunities for existing firms to abuse the regulatory process so as to further prevent or delay new competition.[23] CON regulation, therefore, makes entry and expansion less likely, or at least less rapid. Firms in any given market need not be as competitive on 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.

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.[24] 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

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22 An evaluation of the CON program in Michigan found that the number and complexity of CON appeals increased dramatically from 1979 to 1986. Comparative reviews were found to be particularly protracted. Michigan Statewide Health Coordinating Council, An Evaluation of the Certificate of Need Program (March 19, 1987) at 29-34. See also Hospital Corp. of America [Chattanooga acquisitions], 106 F.T.C. at 490-92.

23 Calvani & Averitt, The Federal Trade Commission and Competition in the Delivery of Health Care, 17 Cumberland L. Rev. 293 (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.

24 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.

effects from the mergers.[25] CON regulation can thus render anti-competitive otherwise lawful conduct, and aggravate the anti-competitive effects of antitrust violations.[26]

In addition, the process of undertaking CON regulation may delay the introduction and acceptance of innovative alternatives to current costly treatment methods because regulators lack the information necessary to evaluate the demand for new treatment alternatives. For example, it is difficult to predict demand for ambulatory surgery or any other innovative service, such as home health care.[27] While state health-planning agencies might provide information or guidance on future trends, as innovations are rapidly becoming more accessible due to improvements in technology

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[25] American Medical Int'l, Inc., 104 F.T.C. at 200-01 (1984). In Hospital Corp. of America [Chattanooga acquisitions], 106 F.T. C. at 489-496, the Commission accepted the administrative law judge's finding that, in combination with Tennessee's CON process, Georgia's regulation of new hospital construction had exacerbated the anticompetitive effects of a hospital merger in Chattanooga, Tennessee. In the absence of Georgia's CON restrictions on hospital entry, a new hospital might have been located in the Georgia suburbs of Chattanooga that would have acted to offset the increase in market power resulting from the unlawful merger.

[26] 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 pursue efficiencies without also creating unacceptable risks of anti-competitive effects.

[27] In Pennsylvania, action on all CON applications for freestanding ambulatory surgical centers (FASCs) was delayed by six months while a CON task force reviewed the issue. FASCs offer an innovative, less costly alternative to inpatient surgery. Legislative Budget & Finance Committee, Report on a Study of Pennsylvania's Certificate of Need Program, February 1987 (hereinafter "LBFC Report"), at 16 - 20. Evidence suggests that the growth of FASCs generally has been hampered by the CON process. Ermann & Gamble, The Changing Face of American Health Care, Medical Care, 1985, at 407.

and greater acceptance by physicians, provider firms have incentives to gather their own information (e.g., by paying for market research) and to adjust rapidly to unexpected changes in trends. For these reasons, reliance on market forces is likely to provide greater flexibility in adapting to changing conditions while the need to meet CON requirements will eliminate or postpone adjustments in rapidly changing health care markets.

D. CON Regulation Is Not a Good Method for Assuring Access to Care for Indigent Patients.

It has also been asserted that CON regulation must be retained in order to protect access to care for indigent patients. According to this theory, CON regulation prevents the construction of facilities that would siphon off paying patients, leaving those facilities that treat indigent patients with no way to make up their losses.[28]

However, CON regulation may be a highly inefficient means of trying to assure care is available for indigent patients. By insulating providers from new competition, CON regulation, in effect, imposes a "hidden tax" on all consumers of health services in the form of higher prices. That "tax" may be more costly to society than conventional forms of taxation because the CON process interferes with the efficient production and delivery of health-care services. Moreover, the burden of that "tax" falls disproportionately on those in poor health.[29] Alternative mechanisms for funding care for indigent patients have been proposed that would not impair the efficient functioning of health care markets.[30]

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28 LBFC Report at 4-5.

29 See Posner, Taxation by Regulation, 2 Bell J. of Econ. 22 (1971); Havighurst, Regulation of Health Facilities and Services by "Certificate of Need," 59 Virginia L. Rev. 1143, 1188-94 (1973).

30 For example, rural hospitals whose viability (and ability to serve the indigent) is threatened by declining occupancy rates could be encouraged to convert beds to long-term care. M. Lerner, et al., Investigation of Certain Issues in Connection With the Virginia Certificate of Need Law, at VII, 13 (final report, Aug. 10, 1987). The same Report concludes that cost reduction (the original goal of CON regulation) and improvement in access may be "mutually inconsistent goals," and summarized efforts by the states to find alternative methods for funding indigent patient care. Id. at part VII, 23-34, citing FAHS Review, "Review's 1986

E. The Asserted Lack of Information About the Quality and Cost of Health Care Services Does Not Justify CON Regulation

The unavailability of consumer information about health care quality and cost has also been cited as a reason for continuing CON regulation. However, health care providers, third-party payers, and other groups have strong incentives to provide consumer information and can be expected to provide more of it as the market becomes more competitive. These incentives to provide information should increase in the absence of the CON process, which insulates providers from competition.

III. ENACTMENT OF S.B. 398 WOULD REPRESENT A BENEFICIAL, THOUGH LIMITED, RELAXATION OF GEORGIA'S CON REGULATION

For the reasons discussed above, Georgia's CON process may have an adverse effect on competition in the state's health care markets, increasing the price and decreasing the quality of health care services. If so, then passage of S.B. 398 should result in a beneficial reduction in the costs that CON regulation imposes on health care consumers in Georgia. However, two of the bill's provisions appear to diminish its potential benefits to health care consumers. These provisions are (a) the bill's limitation to a one-year period, and (b) the exclusion from its coverage of home health care and inpatient nursing care.

We encourage the sponsors of S.B. 398 to reconsider its exclusion of inpatient nursing care and home health care. A 1986 FTC staff report concluded that CON regulation does not decrease, and may increase, the costs of home health care.[31] Similarly, a study of the economic behavior of nursing homes has noted that CON regulation may have increased the average cost of nursing home services.[32]

Moreover, by restricting the relaxation of Georgia's CON regulation to a one-year period, the potential consumer benefits

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State-by-State Survey: A Special Report," Sept./Oct. 1986 at 27-42.

31 Anderson & Kass, supra note 4, at 74, 82.

32 Lee, Birnbaum, and Bishop, supra note 14, at 1906.

of S.B. 398 are further limited. Although the bill's enactment should provide substantial relief for any present underinvestment in beneficial health care facilities and services that is due to the past imposition of inefficient CON constraints (i.e., some investment opportunities that have been deterred in the past by the actual or perceived inability to obtain CON approval could now be undertaken), it would leave in doubt the status of future beneficial investment opportunities that would be undertaken if the bill provided for a more extended, or permanent, relaxation of Georgia's CON constraints. Because of the time restriction, some beneficial investment opportunities that arise in the future will be blocked by the resumption of CON regulation at the conclusion of the one-year period. On the other hand, some investments in facilities and services that would be postponed until a more opportune time--if passage of S.B. 398 either abolished CON regulation altogether or relaxed its effectiveness for a longer time--may be made during the one-year open period. Those capital outlays accelerated by the anticipation of CON regulation's resumption at the close of the one-year window may combine with those investments in health care facilities and services which, absent CON regulation in the past, would have been made in earlier years, to cause a surge of capital expenditures during the one-year open period. It should be emphasized, however, that even though the accelerated investments might be distributed more efficiently over time if the time period provision in S.B. 398 were longer, health care consumers would still likely be better off with the bill's proposed one-year window than they would be if Georgia's prevailing CON regulatory scheme is not relaxed at all.

CONCLUSION

We believe that the continued existence of CON regulation may be contrary to the interests of health care consumers in Georgia. 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 problems 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 work counter to that purpose because it interferes with competitive market forces that would otherwise help contain costs. More importantly, CON regulation tends to foster higher prices, lower quality, and reduced innovation in health care markets. We conclude that enactment of Senate Bill 398 by the General Assembly would likely have beneficial consequences for Georgia health care consumers and believe the results of the bill's enactment would

provide an incentive for further reductions of CON regulation in the future.

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,

Paul K. Davis
Director
Atlanta Regional Office