



Certificate of Need Program for Idaho

Introduction

During the Great Depression and World War II few new hospitals were built in the United States. A large number of communities had no hospital, and many existing hospitals were quickly becoming obsolete. In response, individual communities began to organize planning and fund-raising efforts to build hospitals. Community planning efforts became particularly important in 1946 with the passage of the federal Hill-Burton Act, which provided federal subsidies for hospital construction.

The availability of Hill-Burton funds created a federally-sponsored, 30-year hospital bed construction boom. In addition, fee-for-service insurance agreements allowed providers to be reimbursed for investment costs. As a result, state and federal governments found themselves faced with both skyrocketing medical costs and a continuing uneven distribution of medical services, leading to the first state certificate of need (CON) programs in the 1960's and early 1970's.

During the 1970s the federal government encouraged states to control rising health care costs by managing the growth of health care services and facilities through health planning. In 1974, federal standards were established and federal funds were authorized to support state CON programs through the National Health Planning and Resources Development Act. States implemented CON to contain costs, improve access, monitor quality, or simply to meet federal requirements. By 1980, all but one state (Louisiana) had a CON program.

In 1982, the federal government began to give states the freedom to set their own CON criteria or to abolish their programs altogether. Idaho's CON statute was allowed to sunset in 1983. In 1986, the federal health planning law was repealed, removing the federal government from any role in state CON programs. Now, in spite of the lack of a federal mandate, 36 states and the District of Columbia continue to have CON programs.

Today, Idaho's healthcare landscape is on the brink of significant, lasting change. With a good liability environment and lack of any review process, Idaho is ripe for out of state investors more interested in profit than the commitment to our communities that our healthcare providers have shown so far.

Definition of CON

Certificate of Need (CON) is a regulatory review process that requires certain health care providers, such as hospitals, to obtain authorization from the state before building new facilities, acquiring high cost medical equipment or expanding beds.

The purposes of CON are to:

- promote health care cost containment;
- facilitate smart growth in health services and facilities
- prevent unnecessary duplication of health care facilities and services;
- guide the establishment of health facilities and services that will best serve public needs.

The proposed CON statute would apply to:

- the construction of new health facilities valued at \$1,000,000 or more;
- the acquisition of major medical equipment valued at \$500,000 or more;
- an increase in acute care beds of existing facilities;

The proposed CON statute would not apply to:

- clinics or physician offices where major medical equipment is not used;
- mental health facilities;
- detoxification or substance abuse treatment facilities;
- hospitals operated by the state of Idaho, the state mental health authority or by the Idaho Board of

- Corrections;
- hospitals operated by the federal government or facilities established solely for treatment of members or former members of the armed forces;
- intermediate care facilities for the mentally retarded; and
- nursing homes and residential or assisted living facilities.

Why Idaho Needs an Effective CON Program

Healthcare is delivered in a highly regulated environment, making free market forces ineffective.

Opponents of CON continue to argue that the best way to assure quality, efficiency, access, innovation, and lower prices is to rely on competition and market forces—the cornerstones of a free market. This argument appeared again in a 2004 report from the Federal Trade Commission entitled "*Improving Health Care: A Dose of Competition.*" The executive summary of the report concluded with the following statement:

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

Fortunately, health care delivery is not provided in the "impersonal working of the marketplace." It is provided in local communities by community-oriented hospitals and providers, and it reflects community values and needs. Healthcare is provided in a highly regulated and controlled environment that is not consistent with a free market. As a result, the presumed beneficial effects of competition are not achievable in the health care system unless the following barriers to a "free market" are removed:

- The requirement that hospitals must provide care in all urgent and emergent circumstances regardless of the patients' ability to pay for those services;
- Legislatively mandated health care services;
- Legislatively mandated health insurance benefits;
- Third party payer influence in provider and service selection;
- Mandated payment rates for services provided to Medicare and Medicaid beneficiaries; and
- Physician control of services received by patients (supply induced demand).

Unless these barriers are removed or changed, community-based planning, licensure and CON regulation will be needed to ensure that services will be available to meet the needs of Idaho's citizens.

CON helps contain health care costs

Many business leaders regard hospital expansions and the proliferation of high-cost technology as a primary reason health care costs are increasing. CON discourages the proliferation of duplicative facilities, services and equipment.

While some might argue that free market forces of supply and demand lead to lower costs, three major automobile manufacturers—General Motors Corporation, Ford Motor Company, and DaimlerChrysler Corporation—have not found that to be true. Independent studies conducted by all three of these multi-state corporations, with similar benefit plans, consistently found that the costs of health care per person were significantly less in states with CON than in states without CON.

The following conclusions from those studies are particularly revealing

From DaimlerChrysler Corporation (DCC) -

- In DCC's traditional and PPO programs, the costs of health care per person are significantly less in states with CON programs than in states without CON. What is notable is that the design of DCC's health benefit programs does 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. DCC's costs for health care are considerably higher in non-CON states, such as Wisconsin and Indiana, than in CON states such as Delaware, Michigan and New York. DCC's three lowest cost areas are in states with CON laws in place, while the two highest cost areas are in the state without CON laws.

From Ford Motor Company -

- Indiana and Ohio, which eliminated CON coverage for most services, consistently had the highest relative costs.
- Michigan, with a CON program since 1972 covering a wide range of services, consistently had among the lowest relative costs.
- Kentucky and Missouri, which also have had CON programs covering a wide range of services, also had low relative costs.
- This consistent correlation between CON and lower costs was quite notable because the pattern was the same across a range of different services. This was true for the broad but differing categories of hospital inpatient and outpatient services, and the narrower focus on CABG (an inpatient surgical procedure) or on MRI (a diagnostic service, mostly done on an outpatient basis).

From General Motors Corporation (GM) -

- At GM, we believe that improving health care quality will reduce costs. It is a continual effort to balance quality, access and costs, but we believe it can be done through delivering the right services, for the right patients, at the right time. We believe improving quality means preventing overuse, under use and misuse of the health care system by reducing unnecessary, duplicative and wasteful services. We strongly believe in fostering the same kind of continuing quality improvement efforts in the medical community that we apply to our own business. We do not believe that unbridled expansion of health care services will lead to improved quality, affordability or accessibility.
- While the GM populations served and the benefits and cost-shaving provisions are quite similar in all four states, our health care costs are highest in Indiana—a state with no CON regulation—and lowest New York—a state with stringent CON regulation.

A study in *Health Affairs-The Policy Journal of the Health Sphere*, 05 November 2003, evaluated the relationship between the supply of new technologies and health care utilization and spending, focusing on diagnostic imaging, cardiac, cancer, and newborn care technologies. The study found that increases in the supply of technology tend to be related to higher utilization, as evidenced in states like Pennsylvania and Ohio after CON was repealed.

Further Notes on Cost Containment --

- With national spending levels estimated at \$100 billion annually, diagnostic imaging has become a major factor in the cost of health care in the United States, second only to pharmaceuticals for most health plans. There is evidence that this growth in spending is linked to the proliferation of imaging centers being developed as "private physician offices," which are typically exempted from CON. Based on the following data, Idaho's proposed CON legislation does not exempt imaging centers.
 - The American College of Radiology (ACR) indicates that the number of MRI scans in the United States increased by more than 45% over a two-year period; from 9.3 million in 1999 to 13.5 million in 2001.
 - Although hospitals already have imaging equipment and capacity, studies show that imaging procedures are being moved out of hospitals. The Radiological Society of North America (RSNA) reported that between 1997 and 2002 the proportion of noninvasive diagnostic imaging performed in hospitals fell from 33.6% to 28.4% while imaging at private offices and freestanding centers rose from 28.1% to 32.6%.
 - Another study in 2001 using Medicare Part B claims data found that 40% to 54% of all MRI scans were done outside of hospitals in physician offices or freestanding centers.
 - The American Health Planning Association found that residents in states with CON have lower MRI use rates than residents of states without CON.

Good health planning helps ensure access to services

CON ensures sustainability of the community hospitals who care for our citizens by restricting the development of "boutique hospitals" which tend to offer lucrative services to insured patients. When boutique hospitals siphon off the community hospital's insured patients and fail to offer low-revenue services, community hospitals are forced to provide a higher percentage of low-revenue procedures, substantially

compromising their ability to continue to provide charity care.

In 2003, Congress imposed an 18-month moratorium on the development of new physician-owned specialty hospitals due to concerns about their negative impact on community hospitals. In March of 2005, the Medicare Payment Advisory Commission (MedPAC) issued a report finding that physician-owned specialty hospitals treat fewer severely ill patients and concentrate on particular DRGs which are relatively more profitable. The report also found these specialty hospitals are often located in states without CON laws, are less likely to have emergency departments, and treat a lower percentage of Medicaid patients.

CON helps safeguard quality of health care services.

CON helps maintain service quality by limiting the number of locations in which specialized and high risk medical procedures may be performed. CON encourages the development of specialized regional health care services, which leads to more cases per provider, better treatment outcomes (e.g., lower mortality), more cost-effectiveness, and the development of more comprehensive and capable service programs.

After allowing its CON law to expire in 1996, Pennsylvania experienced dramatic growth in the number of open heart surgery programs, which increased from 35 to 62. However, volume of cases per hospital dropped from 499 in 2000 to 408 in 2002—fewer than the 450 bypasses per year recommended by the Leapfrog Group, a national coalition of employers working to improve quality of health care.

Researchers at the University of Iowa studying more than 900,000 cases of open heart surgery performed from 1994 to 1999 found that the volume of procedures per program was 84 percent higher in CON states and the odds of death were 22 percent lower for patients receiving coronary artery bypass graft (CABG) surgery in states with CON regulation as compared to similar patients in non-regulated states. Mortality rates were lower in CON-regulated states during the entire six-year period and in each year covered by the study. According to this study, the difference between CON and non-CON states is nine preventable deaths for every 1,000 procedures.

CON and Rural Communities

The need for smart growth in healthcare goes far beyond the Treasure Valley and other urban Idaho areas. The inability to promote reasonable, sustainable growth in small rural areas jeopardizes the ability of small hospitals to provide necessary care to the communities they serve. Rural facilities rely on revenue from a full scope of services to make the hospital economically viable, creating a delicate balance where the reduction or elimination of one revenue stream can have significant effects on the ability to provide other vital services. Good health planning is essential to continued access to care in small Idaho communities. Likewise, the presence of a hospital is vital to economic development in these same communities.

CONCLUSION

The empirical evidence is clear. While CON is not a perfect system, it is the best approach available to protect community resources and safeguard access to care and quality of services. Therefore, the Idaho Hospital Association strongly supports the implementation of a state CON program.

For more information about CON and other healthcare legislation, please contact:

Steve Millard
President
208.338.5100 x 203
samillard@teamiha.org

Toni Lawson
VP, Governmental Relations
208.338.5100 x 207
tlawson@teamiha.org