FINAL RESULTS – CON TASK FORCE SURVEY

Key Survey Findings: Survey findings show that CON Task Force members believe that Connecticut should have a CON program or some other regulatory process in place in order to shape the state's health care landscape. Results are mixed as to the individual factors that should be the goal of such regulation (i.e. access, quality, cost, planning, need, and competition).

Key Research Findings: Task force staff have reviewed numerous studies and articles regarding the effectiveness of CON programs. While research findings are mixed, with arguments being found both in support and opposition of the value of CON laws, the following key findings are:

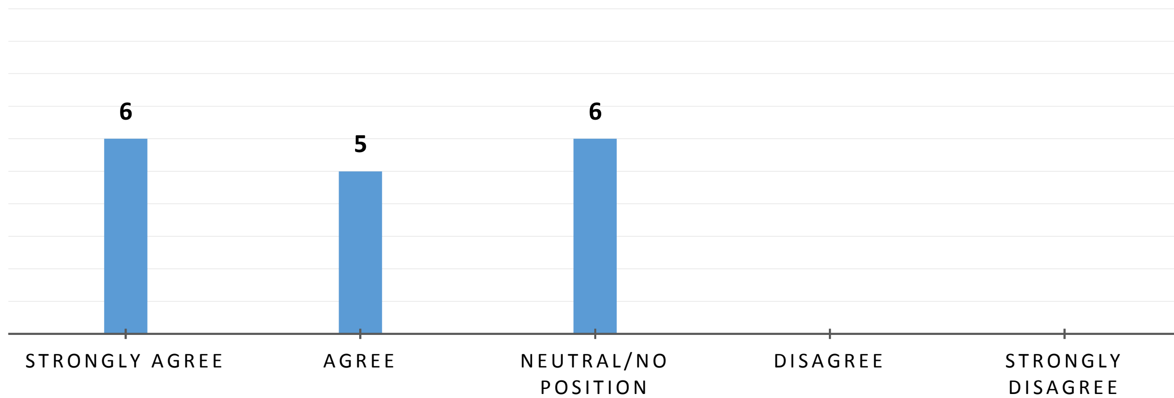
- Limiting excess capacity does not result in lowered health care costs. In addition, limiting capacity through CON programs can give preference to incumbents in the system and actually impede access to services, especially new technologies.
- Other trends in the health care landscape such as limited competition due to mergers, acquisitions, vertical integration, and consolidations are increasing health care costs.
- In general, competition, particularly between hospitals, improves quality of care. Research regarding the ability of CON to affect quality are mixed, with studies often reporting evidence of success as being inconclusive or needing further study.

Key Task Force Questions for July 18th Meeting:

- Is a CON program or other regulation needed to achieve all desired outcomes or can free market forces achieve some ends?
- What goals should regulation achieve?
- What factors does regulation need to focus on in order to achieve the established goals?

Next Steps:

- Evaluate whether the following is aligned with determined purposes and goals:
    - Services subject to CON or actions that trigger CON
    - Criteria or standards used to determine whether a CON is approved
    - Review process including organizational structure of the decision-makers, transparency, ability for public input
    - Evaluation methods to ensure purpose and goals are being met
- Identify any remaining challenges or gaps in state efforts to regulate health care services
- Draft and finalize recommendations



No task force member indicated that Connecticut should not have a CON program or some other regulatory process in place to shape the state's health care landscape. Although members' views differ on the purpose and goals of this process, the existence of some form of regulatory oversight is a potential area of consensus.

KEY COMMENTS FROM TASK FORCE MEMBERS:

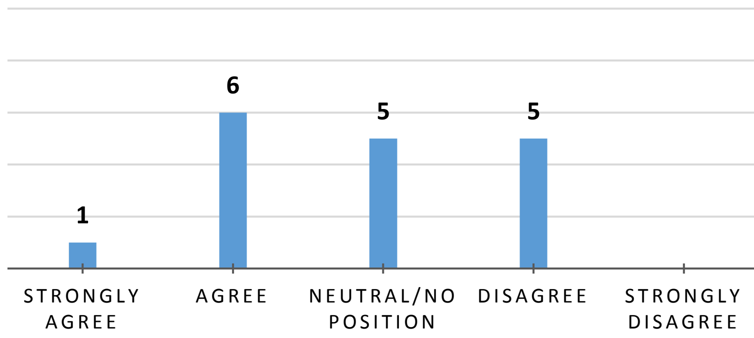
"I am concerned that these questions […] presuppose a need for an overarching regulatory structure, and I'm not sure I agree."

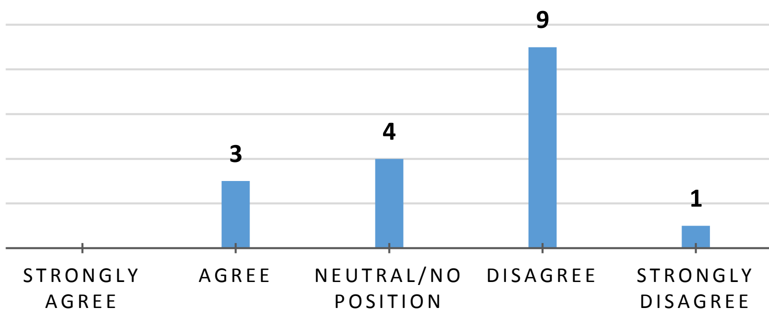
"[T]he CON question is part of the broader regulatory effort to cope with the rapid transformation of the health care system. It can't be viewed in isolation from the work of the Cabinet or other bodies."

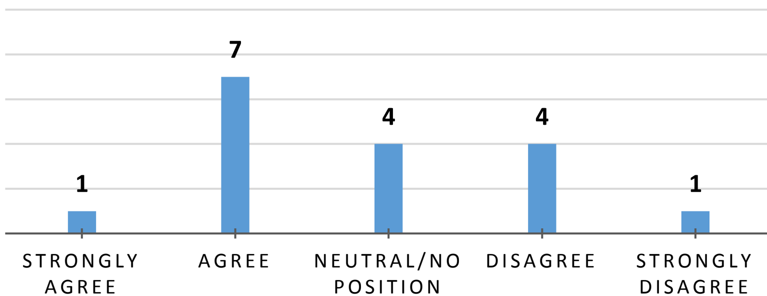
RESEARCH FINDINGS: Currently, 35 states and the District of Columbia have a CON program, and California has a similar process of review through its Office of the Attorney General. These programs vary widely in the type of services requires CON review, the designated agency charged with the review, the criteria of review, the public participation in the review, and the existence of post-approval mechanisms and enforcement.

33 states, including D.C., have a CON program that applies to hospitals and their various transactions[i].

- **Actions that Trigger CON:** Of these states, a CON review is triggered for various hospital actions: 33 require CON for new hospital construction; 5 states require CON for hospital closures; 8 states require CON for hospital transfer of control; and 8 states require CON for loss of health care services.
- **CON Application Review:** 18 states have a joint administrative team and appointed board make final CON decisions and 9 states require consumer representation on this board.
- **CON Application Considerations:** 22 states consider whether the project is compatible with state health planning goals; 25 states consider whether the project is financially feasible; 17 states consider whether the project impacts underserved populations; and 11 states consider whether the project impacts health care access within a geographic region.
- **Public Communication:** Almost all of the CON states have a public website with details about the CON process, regulations, and statutes, with 23 of those websites being considered "easy" for the consumer to find information. 24 states post each CON application with public hearing dates and guidance on comment submission and 18 states notify the public about CON applications via newspaper or another platform.
- **Public Input:** 7 of the states have public input into the review process by allowing them to testify at regularly scheduled review board meetings. 19 states allow public participation in the review process through written comments. In 22 states, public hearings on CON applications are held by public request, and 5 states have mandatory public hearings for CON applications.
- **Post-Approval**: In 19 states, after a CON is denied, there is a post-approval challenge process. In 27 states, after a CON is approved, there is some sort of mechanism for enforcing compliance.







RESEARCH FINDINGS:

The underlying premise of the CON process when implemented nationally in the early 1970s revolved around the idea that overbuilding, expanding, or purchasing capital equipment would drive up health care costs if it resulted in excess capacity. CON programs were designed to restrict new or additional health care facility construction or equipment to only those entities that could demonstrate a genuine need.

However, recent changes in health service reimbursement that move away from pure "cost-based" systems to payments based on quality or diagnosis have diminished incentives for health care providers to expand regardless of demand.[ii] As a result, the original purpose of CON - the limiting of expansions or added capacity to the health care system – no longer seems to be applicable in holding down health care costs.

It has been shown[iii] **that the consolidation and merging of health care facilities and services, through limiting competition is a primary driver in increasing health care costs.**

While some studies[iv] have shown that CON states, in comparison to non-CON states, have decreased health care costs, these studies rely on correlation only and cannot claim that the existence of CON resulted in the lower costs. Other studies[v] have shown that CON programs have actually increased costs.

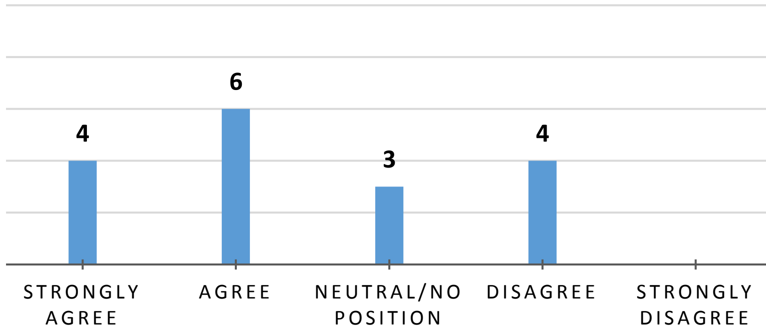
Research has shown that limiting capacity in this way can give preference to incumbents in the system and actually impede access to services, especially new technologies.[vi]

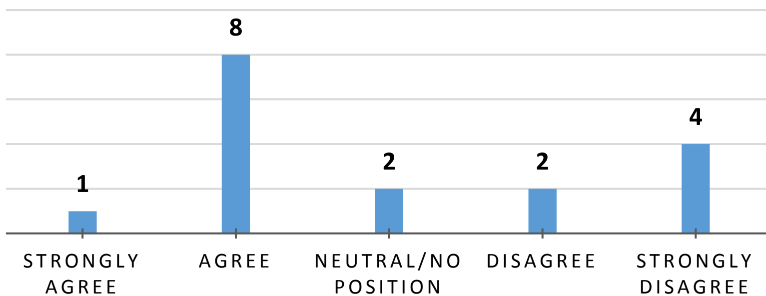
KEY COMMENTS FROM TASK FORCE MEMBERS:

"At the level of acute care hospitals, the notion that new market entrants will provide competition seems far-fetched, Below that level, competition can be beneficial for outpatient and ambulatory services, but creating incentives for over prescription (which is the real driver in parts of the system where overutilization is a problem), is hard to avoid."

"Induced demand is a major factor in health care. Self-referral of procedures and tests is a major driver of health care costs."

"Our current system has not controlled costs. The segments of health care which currently operate in a "market environment" with price transparency and competition have seen relative costs actually decrease. Current regulatory, reimbursement, and "health care reform" are clearly driving more and more care into the hospital environment which is unquestionably more expensive."





RESEARCH FINDINGS:

There is significant debate around whether health care services operate under the same market pressures as other service industries where competition reduces price and improves quality.

In general, opponents of CON programs argue that free-market forces apply to the health care industry[vii] while proponents assert that market forces alone do not control service growth spending cost, quality, or access[viii].

There are many other factors that influence patient choice other than price – patients are often insulated from actual costs due to third party payment. Proximity, availability of subspecialty services, relationships with providers, and convenience (such as extended hours) are all factors that come into play when a patient selects services[ix].

In addition, most health services, such as labs, x-rays, or other tests, are ordered by providers; patients do not "shop" for these services like other commodities[x].

The non-profit status of a hospital does not play as large a role in curtailing costs as once thought. Studies[xi] show that non-profits are affected by the same market pressures as for-profit hospitals and are just as likely to have prices rise based on market pressures.

KEY COMMENTS FROM TASK FORCE MEMBERS:

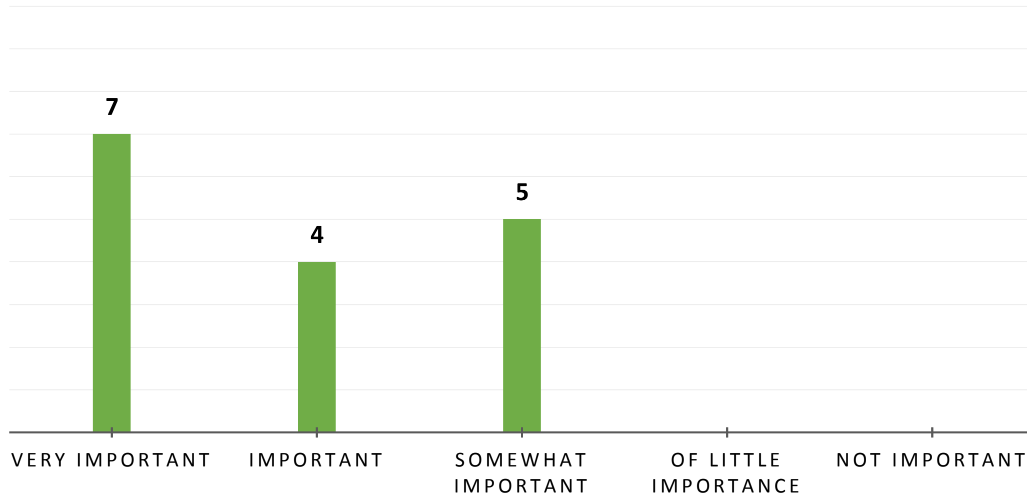
"To me, [the] vision of competition based on quality and access is really a vision of using robust regulation to establish the terms of practice. The idea that individual consumers will use data to make choices to maximize price and outcomes is a dangerous mirage. The overwhelming majority of decision-making on health care services is driven by forces exogenous to the patient. Market forces don't apply in health care transactions for two reasons. The minor reason is the extreme imbalance of technical knowledge, which won't be overcome by websites. But the major reason is that patients who are suffering have diminished moral agency. Rational choice theory, the basis for all market model construction cannot apply."

"Carefully regulated, competition can provide some level of price control. But competition has been the primary cost control strategy in the US for 50 years, and US health care costs have mushroomed at two or more times the rate of inflation the whole time [..] Regardless of the efficacy of competition, the FTC has allowed providers to consolidate so deeply that "unscrambling the egg" of large systems would be the only way to restore competition. That seems legally, administratively and financially impossible. We should nurture competition where possible, but recognize its severe limitations as an overall strategy."

"While I don't see that CON controls costs, there are other reasons to regulation the health care system through CON."

WHAT GOALS SHOULD REGULATION ACHIEVE?

PLANNING
Aligns with state-wide health planning goals



KEY COMMENTS FROM TASK FORCE MEMBERS:

In response to the question asking if other factors not listed in the survey should be considered, a task force member said *“age and condition of the existing infrastructure*”.

" ‘Planning,’ in my view does not belong on this list. A system dedicated to cost-effective, access to quality healthcare would naturally include a robust cross-cutting planning process to meet public health needs.”

“CON should be a process that allows the regulatory body to assess whether a proposed new or expanded service will enhance or harm the community's, or the state's, overall health care delivery system.”

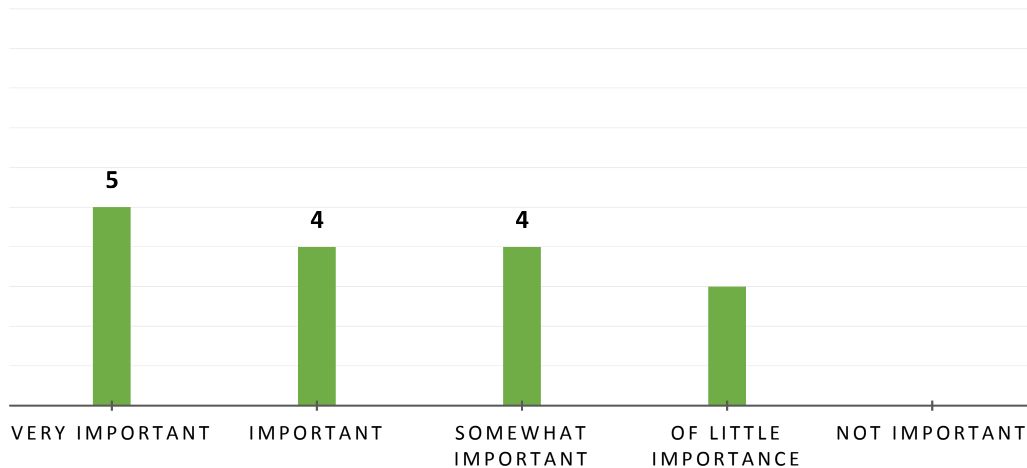
“CON should be a process that allows the regulatory body to assess whether a proposed new or expanded service will enhance or harm the community's, or the state's, overall health care delivery system.”

NOTES:

- OHCA is tasked with establishing and maintaining a state-wide health care facilities and services plan and conducting a state-wide health care facility utilization study[xii].
    - Blueprint for health care delivery in the state and include an inventory of all facilities, services, and equipment.
    - Examines unmet need and identifies possible gaps in services and at-risk and vulnerable populations, as well as containing standards and guidelines for best practices for specific services
- Almost half of the states (43%) that review various hospital transactions in their CON programs include compatibility with state health planning goals as review factor.[xiii]

DISCUSSION:

- Does Connecticut have adequate and clear state-wide health planning goals?
- Which entity should be responsible for developing and implementing state-wide health planning goals?
- Should the CON review process include criteria on the alignment of the application with state-wide health planning goals?



KEY COMMENTS FROM TASK FORCE MEMBERS:

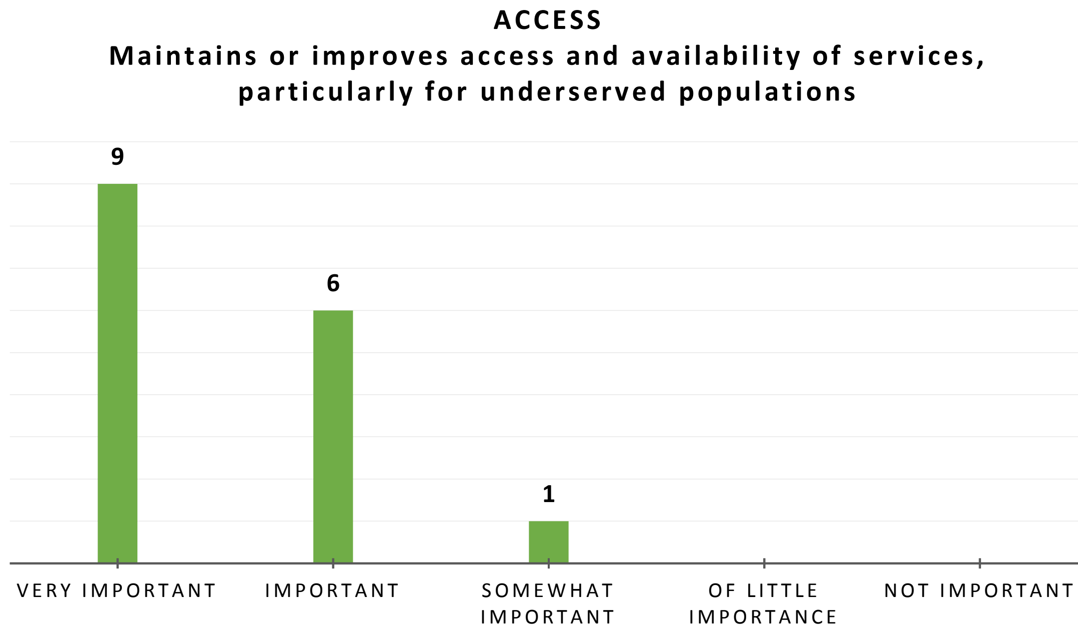
" 'Need' and 'Quality' are obviously important but are not manageable, in my view, through a CON process."

NOTES:

- The underlying premise of the CON process when implemented nationally in the early 1970s revolved around the idea that restricting new health care facility construction or the addition of health care equipment or beds to only those entities that could demonstrate a genuine need.
- Most studies[xiv] demonstrate that there is no evidence that CON programs are successful in containing health care costs. Instead of relating costs to whether or not capacity is limited, studies shows that it is actually the consolidation and merging of health care facilities and services is a primary driver in increasing health care costs[xv].

DISCUSSION:

- Should the state limit the addition of health care services and equipment? If so, is a CON program to most effective vehicle in which to accomplish this?
- Are there other ways that excess capacity will be naturally limited without the state's regulation?
- Does limiting "excess capacity" or "duplication" have an inadvertent effect on access?
- Should the CON review process include criteria on demonstrating a clear need or avoiding duplication of services?



KEY COMMENTS FROM TASK FORCE MEMBERS:

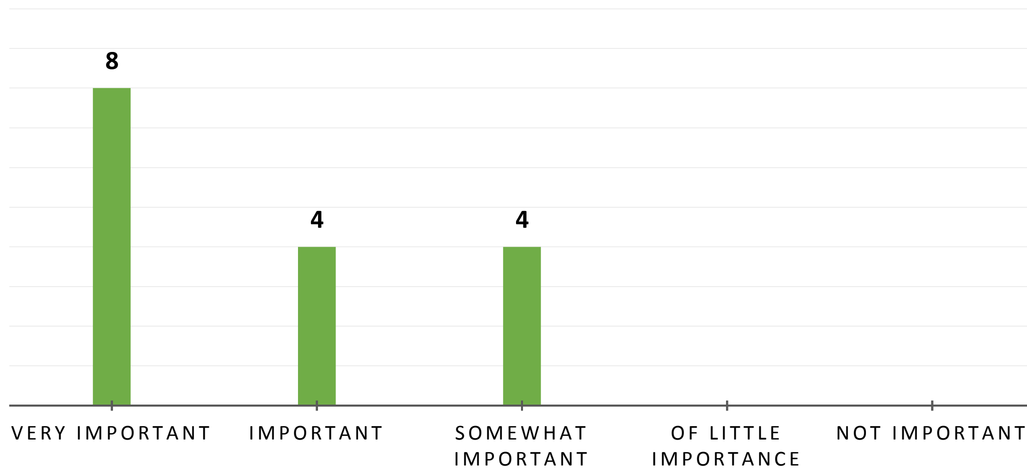
"I would like to underscore the importance of improved access and quality of care from a health equity viewpoint. This is critical to the CON process. Not only for racial and ethnic minority populations but also for women."

NOTES:

- Research indicating that CON programs have improved access to care for the underserved or increased uncompensated care is limited, with mixed results.[xvi]
- By limiting capacity in the health care market, CON programs give preference to incumbents in the system which can impede access to services, especially new technologies.[xvii]
- Better access to primary care lead to fewer hospitalizations[xviii].

DISCUSSION:

- Does improving or increasing access to services lead to "excess capacity"?
- Should the state regulate the reduction or termination of services, as it relates to access?
- Should the CON review process include criteria on maintaining or improving access and availability of services, particularly for underserved populations?
- Since better access to primary care leads to fewer hospitalizations, should focus on access be more on physician networks than hospitals?
- Does Connecticut's current CON process adequately measure access when reviewing applications?
- How can we measure access in a CON application? How is access defined – is it a certain distance, market share, or just the mere presence or lack of certain types of services?



KEY COMMENTS FROM TASK FORCE MEMBERS:

"As noted, the CON question is part of the broader regulatory effort to cope with the rapid transformation of the health care system. It can't be viewed in isolation from the work of the Cabinet or other bodies."

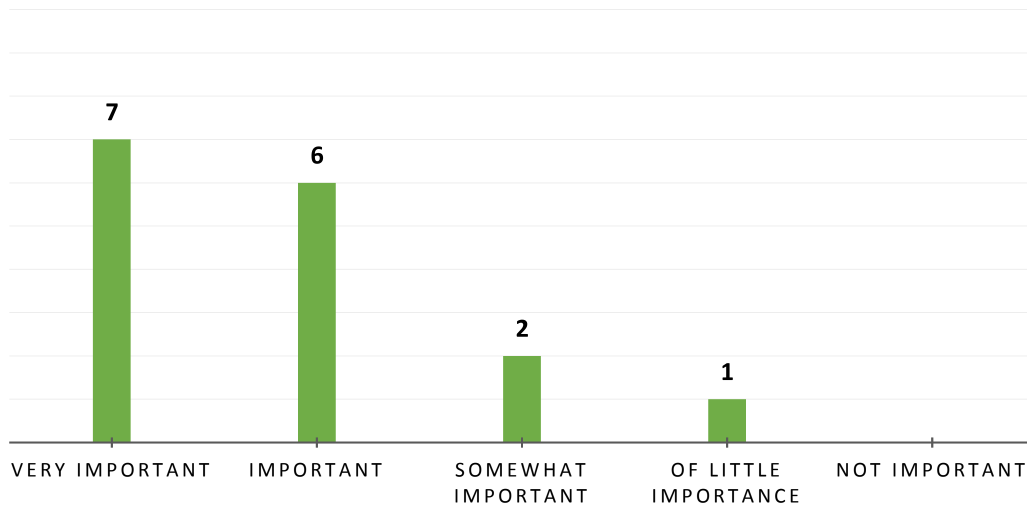
"While I don't see that CON controls costs, there are other reasons to regulate the health care system through CON."

NOTES:

- While some studies[xix] have shown that CON states, in comparison to non-CON states, have decreased health care costs, these studies rely on correlation only and cannot claim that the existence of CON resulted in the lower costs.
- It has been shown[xx] that the consolidation and merging of health care facilities and services, not an excess of capacity or duplication, is a primary driver in increasing health care costs.

DISCUSSION:

- Can CON be an effective tool for managing health care costs? Would the addition of more stringent post-approval review and monitoring help?
- What role does competition play in managing health care costs? Should CON program goals relating to cost containment be focused on maintaining competition rather than limiting supply?
- Should the CON review process include criteria on maintaining or improving cost-effectiveness or affordability of services?



KEY COMMENTS FROM TASK FORCE MEMBERS:

"I would like to underscore the importance of improved access and quality of care from a health equity viewpoint. This is critical to the CON process. Not only for racial and ethnic minority populations but also for women."

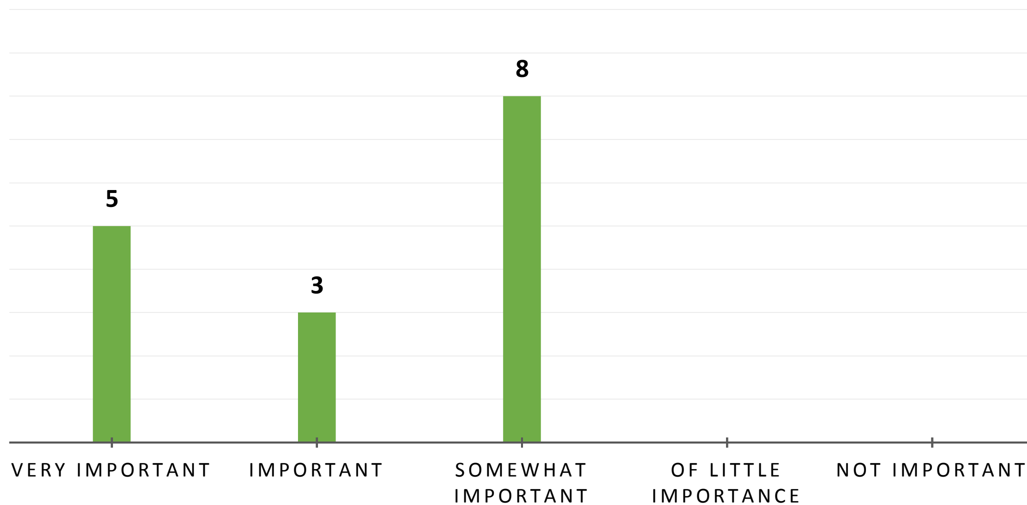
"For quality more interested in improve rather than maintain."

" 'Need' and 'Quality' are obviously important but are not manageable, in my view, through a CON process."

"I rated quality low, not because it is relatively unimportant, but because it is very difficult to evaluate in the CON or any other regulatory process."

NOTES:
- Research regarding the ability of CON to affect quality are mixed with studies often reporting evidence of success being inconclusive or needing further study. In some cases, CON impact on improved quality may be present in certain areas (such as cardiac services) but not in others (such as delaying the acquisition of needed equipment)[xxi].
- While evidence is mixed, there is a growing body of research that supports that, in the US healthcare system, hospital competition improves quality.[xxii] In addition, studies show that physician-hospital consolidation has not led to either improved quality or reduced costs.
- There is not a universally accepted set of metrics for measuring hospital quality. However, available data provides no evidence that Connecticut's high health care costs are correlated to high quality.[xxiii]

DISCUSSION:
- Should the state regulate the quality of health care services? If so, is a CON program the most effective vehicle to accomplish this?
- Should the CON review process include criteria on maintaining or improving quality of health care services?
- Quality is a relative term that can have many measures (e.g. whether a diagnosis is correct; whether the "right" treatment is selected to treat a diagnosis; whether the treatment is performed in a technically competent manner; or whether consumers can access the care they desire). How can quality be weighed and defined in a CON review process?



KEY COMMENTS FROM TASK FORCE MEMBERS:

"Competition is a tool for a regulatory system, not an end in itself. Note also that these answers apply to the full spectrum of regulatory activity, not CON by itself."

"It is unclear to me how the current system preserves competition. Materials submitted, and comments made by the DPH clearly state that the intent of the current system is not to foster competition."

"CON's could be used to actually promote competition, if administered with that in mind."

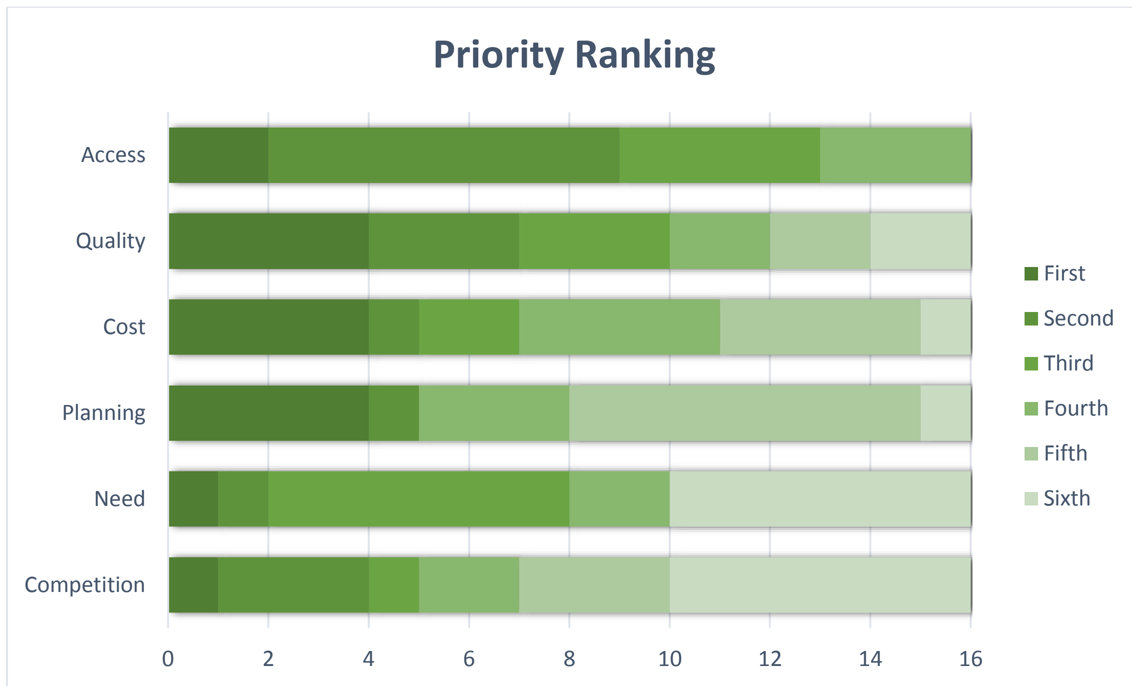
"Competition can be harmful in health care vs. other industries, particularly if new entrants can cherry pick patients."

NOTES:

- In general, research indicates that competition in the health care market enhances quality and lowers costs.[xxiv]
- No studies were found regarding CON programs' effectiveness at promoting or protecting competition. However, research has shown that limiting capacity through CON programs can give preference to incumbents in the system and actually impede access to services, especially new technologies.[xxv]
- Research shows[xxvi] that the consolidation and merging of health care facilities and services, not an excess of capacity or duplication, is a primary driver in increasing health care costs.
- Beginning December 1, 2015, OHCA is required to conduct a cost and market impact review for certain[xxvii] hospital transactions. This cost and market impact review will include a determination of whether a hospital current has or, as a result of the application, is likely to have a dominant market share or materially higher prices[xxviii]. OHCA may deny an application based on the cost and market impact review if it is found that the affected community will not be assured of continued access to high quality and affordable health care or any likely increases in the prices for health care services or total health care spending in the state may negatively impact the affordability of care[xxix].

DISCUSSION:

- Is the goal of CON to preserve competition? Or is competition a means to an end – better quality, access, cost, etc?
- How does the current cost and market impact review evaluate the impact of a hospital CON application on competition?
- Should the CON review process include criteria on preserving an open and competitive health care market?



---

[i] This data is updated as of April 2016 and taken from the MergerWatch report "When Hospitals Merge: Updating State Oversight to Protect Access to Care". This data was considered only when researching how CON programs review hospitals and hospital actions.

[ii] (a) Kenen, Joanne. *"Getting the Facts on Hospital Mergers and Acquisitions."* Association of Health Care Journalists; and (b) The Federal Trade Commission, Department of Justice. (2004). *Improving Health Care: A Dose of Competition*.

[iii] (a) Gaynor, M. and Town, R. (June 2012). *The Impact of Hospital Consolidation-Update*. The Robert Wood Johnson Synthesis Project; and (b) Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*.

[iv] (a) Gendregske, M. J. (March 19, 2002). DaimlerChrysler Corporation. *Certificate of Need: Endorsement by DaimlerChrysler Corporation*; and (b) Hellinger, Fred. (2009). *The Effect of CON Laws on Hospital Beds and Healthcare Expenditures: An Empirical Analysis*; The American Journal of Managed Care, Vol. 15(10).

[v] Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*.

[vi] (a) Ohlhausen, Maureen K. (Fall 2015). *Certificate of Need Laws: A Prescription for Higher Costs*; American Bar Association. Antitrust, Vol. 30, No. 1.; and (b) The Federal Trade Commission, Department of Justice. (2004). *Improving Health Care: A Dose of Competition*.

[vii] (a) Ohlhausen, Maureen K. (Fall 2015). *Certificate of Need Laws: A Prescription for Higher Costs*; American Bar Association. Antitrust, Vol. 30, No. 1.; and (b) The Federal Trade Commission, Department of Justice. (2004). *Improving Health Care: A Dose of Competition.* ; and (c) Yee, T., Stark, L.B., Bond, A. M., and Carrier, E. (May 2011). *Health Care Certificate of Need Laws: Policy or Politics?*: National Institute of Health Care Reform Research Brief, No. 4.

[viii] (a) Yee, T., Stark, L.B., Bond, A. M., and Carrier, E. (May 2011). *Health Care Certificate of Need Laws: Policy or Politics?*: National Institute of Health Care Reform Research Brief, No. 4.; (b) Steen, John. *Certificate of Need: A Review*, American Health Planning Association Articles and Essays; (c) American Health Planning Association. *Improving Health Care: A Dose of Competition, AHPA Response*. American Health Planning Association Articles and Essays; and (d) Piper, Thomas. (July 2014). *Certificate of Need: Protecting the Public Interest, PowerPoint Slides*; National Conference of State Legislatures Website.

[ix] (a) Steen, John. *Certificate of Need: A Review*, American Health Planning Association Articles and Essays. (b) American Health Planning Association. *Improving Health Care: A Dose of Competition, AHPA Response*. American Health Planning Association Articles

and Essays; and (c) Piper, Thomas. (July 2014). *Certificate of Need: Protecting the Public Interest, PowerPoint Slides*; National Conference of State Legislatures Website.

[x] Piper, Thomas. (July 2014). *Certificate of Need: Protecting the Public Interest, PowerPoint Slides*; National Conference of State Legislatures Website.

[xi] (a) Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*.; and (b) Young, G. J. and Desai, K. R. (1999). *Non-Profit Hospital Conversion and Community Benefits: New Evidence from Three States;* Health Affairs, Vol. 18(5).

[xii] §19a-634 of the Connecticut General Statutes

[xiii] Khaikin, C. Uttley, L., and Winkler, A. (2016) *When Hospitals Merge: Updating State Oversight to Protect Access to Care*: The Merger Watch Project.

[xiv] (a) Bosse, Grant D. (February 2012). *Irrational: Do Certificate of Need Laws Reduce Costs or Hurt Patients?*: Policy Matters, The Josiah Bartlett Center for public Policy; and (b) Burt, J. and Williams, Kati. (October 2012). *Certificate of Need (CON) Law Series Part II of IV: The Current State of CON Programs Across the Country*: Health Capital, Vol. 5, Issue 10.

[xv] (a) Gaynor, M. and Town, R. (June 2012). *The Impact of Hospital Consolidation-Update.* The Robert Wood Johnson Synthesis Project; and (b) Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*.

[xvi] (a) Yee, T., Stark, L.B., Bond, A. M., and Carrier, E. (May 2011). *Health Care Certificate of Need Laws: Policy or Politics?*: National Institute of Health Care Reform Research Brief, No. 4.; (b) Conover, C.J. and Sloan, F. A. (June 1998). *Does Removing Certificate of Need Regulations Lead to A Surge in Health Care Spending?,* Journal of Health Politics, Policy and Law, Vol. 23(3); and (c) Stratmann, T. and Russ, J. W. (July 2014). *Working Paper: Do Certificate of Need Laws Increase Indigent Care?* Mercatus Center, George Washington University.

[xvii] (a) Ohlhausen, Maureen K. (Fall 2015). *Certificate of Need Laws: A Prescription for Higher Costs;* American Bar Association. Antitrust, Vol. 30, No. 1.; (b) The Federal Trade Commission, Department of Justice. (2004). *Improving Health Care: A Dose of Competition.*

[xviii] Conover, C.J. and Sloan, F. A. (June 1998). *Does Removing Certificate of Need Regulations Lead to A Surge in Health Care Spending?,* Journal of Health Politics, Policy and Law, Vol. 23(3)

[xix] (a) Gendregske, M. J. (March 19, 2002). DaimlerChrysler Corporation. *Certificate of Need: Endorsement by DaimlerChrysler Corporation*; (b) Hellinger, Fred; *The Effect of CON Laws on Hospital Beds and Healthcare Expenditures: An Empirical Analysis*; The American Journal of Managed Care, Vol. 15(10); 2009.

[xx] (a) Gaynor, M. and Town, R. (June 2012). *The Impact of Hospital Consolidation-Update.* The Robert Wood Johnson Synthesis Project; and (b) Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*.

[xxi] (a) Conover, C.J. and Sloan, F. A. (June 1998). *Does Removing Certificate of Need Regulations Lead to A Surge in Health Care Spending?,* Journal of Health Politics, Policy and Law, Vol. 23(3); (b) Yee, T., Stark, L.B., Bond, A. M., and Carrier, E. (May 2011). *Health Care Certificate of Need Laws: Policy or Politics?*: National Institute of Health Care Reform Research Brief, No. 4; and (c) Gaynor, M. and Town, R. (June 2012). *The Impact of Hospital Consolidation-Update.* The Robert Wood Johnson Synthesis Project

[xxii] Gaynor, M. and Town, R. (June 2012). *The Impact of Hospital Consolidation-Update.* The Robert Wood Johnson Synthesis Project

[xxiii] Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion.

[xxiv] (a) Gaynor, M. and Town, R. (June 2012). *The Impact of Hospital Consolidation-Update.* The Robert Wood Johnson Synthesis Project; and (b) Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*.; (c) Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion; and (d) Yee, T., Stark, L.B., Bond, A. M., and Carrier, E. (May 2011). *Health Care Certificate of Need Laws: Policy or Politics?*: National Institute of Health Care Reform Research Brief, No. 4.

[xxv] (a) Ohlhausen, Maureen K. (Fall 2015). *Certificate of Need Laws: A Prescription for Higher Costs;* American Bar Association. Antitrust, Vol. 30, No. 1.; and (b) The Federal Trade Commission, Department of Justice. (2004). *Improving Health Care: A Dose of Competition.*

[xxvi] (a) Gaynor, M. and Town, R. (June 2012). *The Impact of Hospital Consolidation-Update*. The Robert Wood Johnson Synthesis Project; and (b) Cooper, Z., Craig, S., Gaynor, M. and Van Reenan, J. (December 2015). *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*.

[xxvii] These applications include cases where (1) an application for a certificate of need filed pursuant to section 19a-638 involves the transfer of ownership of a hospital, as defined in section 19a-639, and (2) the purchaser is a hospital, as defined in section 19a-490, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars, or a hospital system, as defined in section 19a-486i, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars or any person that is organized or operated for profit.

[xxviii] §19a-639f of the Connecticut General Statutes

[xxix] §19a-639(d)(4) of the Connecticut General Statutes