

Some studies suggest that hospitals have increased capital investment in anticipation of imposition of CON review, but this conclusion is probably not warranted.¹⁰ They have inferred that an increase in the ratio of total hospital assets to total beds in the year prior to adoption of CON review indicates anticipatory behavior. Given the lead times required for hospital construction and purchase of major pieces of equipment, however, anticipatory behavior is not likely to show up until well after the adoption of CON review. A more likely explanation would be the reverse--that a spurt in hospital capital spending led to passage of the legislation.

The conclusion that CON review has led to increased hospital investment for other equipment can also probably be discounted, although it has a strong analytical basis. One study concluded that CON review led to substitution of investment in other assets instead of hospital beds, but its result is questionable because it used data only for the early years of CON review.¹¹

Some have pointed to recent declines in construction of health facilities and number of hospital beds as evidence that CON review is effective. Rates of growth for both hospital construction and hospital beds above the federal standard have declined in recent years. Expenditures for health facilities construction, after adjusting for inflation, declined by 36 percent between 1972 and 1980.¹² From 1965 to 1974, the average annual rate of growth in the number of general hospital beds was 2.6 percent. Between 1974 and 1980, this rate fell to 1.1 percent.

Although these declines could be a result of successful CON review, there are other possible explanations, some of which may be more compelling. The decline could reflect an end to the period of rapid hospital expansion that occurred in response to the increased demand for services from the Medicare and Medicaid

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10. For example, see Fred Hellinger, "The Effect of Certificate of Need Review on Hospital Investment," Inquiry (June 1976), p. 187-193.
 11. Salkever and Bice, Hospital Certificate-of-Need Controls, p. 45.
 12. U.S. Department of Commerce, Bureau of the Census, Value of New Construction Put In Place, Series C-30.

programs. Low occupancy rates might indicate that hospitals have caught up with this extra demand. Also, hospitals might have less capital available for construction projects as a result of reduced federal grants and loans, slow growth in private grants, rising interest rates, and increased debt burdens. State rate setting could also have played a role. As is frequently the case, the lack of a control group makes it difficult to draw inferences from changes in trends over time.

The major studies found no evidence that CON review reduced the supply of hospital beds. On the other hand, another analysis suggests that, all else being equal, hospitals with the same level of use were found to have a 6 percent lower supply of hospital beds in states with CON review, rate regulation, or both, than in other states. This analysis found that CON review alone also reduced the supply of beds, although the extent of the reduction was not estimated.¹³

Because of the decline in the growth of the number of hospital beds in recent years, the ability of CON review to limit growth in the bed supply may not have been properly tested, however. The difference between the growth rate in states with and without CON review during a period of slow growth is likely to be smaller than during a time of rapid expansion in the bed supply. There is no way of knowing to what extent this factor affected the findings of these studies.

Effects of CON Review on the Proliferation of CT Scanners. Although studies of CON review alone have found no effects, the

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13. Paul L. Joskow, "The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital," Bell Journal of Economics (Autumn 1980), p. 440. The result held when the length of time the CON program was in effect was included as the regulatory variable but not for a dummy variable measure. The 6 percent reduction assumed an average daily census of 200 patients. Data were from a relatively small sample of hospitals in the year 1976. An earlier study, using state-level data from 1969 to 1972, estimated that CON review reduced the rate of growth in the supply of hospital beds between 5 and 9 percent. See Salkever and Bice, Hospital Certificate-of-Need Controls, p. 45. This study used data only from very early years of CON review, and its results must be regarded cautiously.

study that examined the interaction effects of various regulatory programs found that the use of computed tomography (CT) scanner technology was restrained in those states with relatively stringent programs.¹⁴ Although the role of CON review cannot be separated from that of other regulatory programs in this type of analysis, the finding of less use of CT scanners may reflect the contribution of CON review to an overall state regulatory program. Although rate setting could restrain investment by limiting hospital revenues or by excluding unapproved projects from the rate base, CON review has explicit authority to restrict a particular type of investment, such as CT scanners. In many areas, CON review has focused on CT scanners because they are symbolic of the issues involved in the diffusion of costly medical technology, particularly the belief that there is an excess supply of expensive technology which contributes to rising hospital costs.

The evidence from this study and others, however, does not indicate that CON review alone has had an effect on the diffusion of CT scanners.¹⁵ This suggests that the presence of other regulatory programs or a strong commitment to regulation is necessary for successful hospital cost containment.

In addition, although it may indicate a change in the mix of investments, evidence of effects on one type of equipment does not permit inferences to be drawn with regard to total investment. Hospitals may be shifting investments to other equipment rather than reducing overall investment.

Evaluations of the CON Review Process

Some studies have evaluated CON review by considering the results of the review process, but they are of limited use. These findings include the applications accepted, denied, discouraged, withdrawn, or modified.

Data indicate that a very high proportion of CON applications are approved--93 percent of applications and total expenditures--

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14. Urban and Bice, "Measuring Regulation and its Effects on Hospital Behavior."
 15. Policy Analysis, Inc., Evaluation of the Effects, vol. III., p. 343-372.

although rates vary by state, type of facility, and type of applications.¹⁶ Renovation expenditures are more likely to be approved than new construction, and applications from hospitals are approved more often than those from nursing homes.

Although information on the results of the CON review process may indicate what kinds of changes in the investment mix, if any, are encouraged by planning agencies, there are three problems with this approach. First, there is no way to measure the impact of planning on the content of the applications. A high approval rate may indicate that an agency does not affect hospital investment, but can also reflect the success of planners in communicating to hospitals which types of projects have a greater chance of approval. Second, applications can be altered or withdrawn for reasons unrelated to planning agency review. Third, relative approval rates may reflect the relationship between agencies and health facilities more than investment patterns. For example, nursing home approvals may be lower because there is not as much pre-application negotiation between nursing home operators and planning agencies as between hospitals and planning agencies.

As a result, there are serious flaws in techniques that use CON program approval rates or the total dollar value of investments denied to measure program success in controlling total investment and hospital costs. These techniques can overestimate the effects of CON review in two ways. First, applications may include a "fudge factor"--hospitals may not expect to get approval for the full amount they are requesting. Second, hospitals may resubmit project applications after having been turned down initially. On the other hand, because deterrent effects are not picked up in this type of analysis, the effects of CON review can be underestimated. Hospitals may not enter the review process or may withdraw their application if approval seems unlikely.

Evaluation of CON Review on the Distribution of Hospital Beds

The little available analysis of the effects of CON review on the distribution of hospital beds is weak. One analysis of county

16. Department of Health and Human Services, Bureau of Health Planning, unpublished data, including applications approved between July 1, 1979 and June 30, 1980, received as of June 1981.

data indicates that, in states with relatively long-term CON programs, the extent of variation in average bed/population ratios across counties declined over time, whereas this variation increased in the other states.¹⁷

In those states in which the variation was reduced, low-income counties tended to have relative gains in bed/population ratios. This equalizing of bed distribution did not correlate with agency emphasis on distribution, however. States whose agencies stressed better distribution did not show these improvements. Instead, those stressing cost containment achieved results in evening the distribution of beds.

The analysis is weak because it does not control for the effects of other factors. For example, it does not account for the potential effects of rate-setting programs or changes in the supply of physicians. In addition, it does not distinguish changes in the ratio caused by population shifts from those caused by differences in the number of hospital beds. The ratio could have been lowered in some areas because the population increased faster than the supply of beds, for example. Finally, the distribution of hospital beds is often affected by the presence of large urban areas within counties, which would not be picked up in this analysis.

Effects of CON Review on Competition

Hospitals compete for patients in a number of ways, including quality of care, amenities, number of active physicians on their staffs, and prices. Competing through quality care, amenities, or attracting physicians often translates into expenditures for new beds, specialized services, and advanced technology. Given the pervasiveness of third-party reimbursement for hospital care, capital expenditures are a more important means of hospital competition than are prices.

Price and nonprice competition differ in their impact on hospital costs. Price competition would be expected to lower costs, but nonprice competition involves investment that would tend to increase hospital expenses. CON review is intended to control

17. Policy Analysis, Inc., Evaluation of the Effects, vol. II, pp. 251-259.

hospital costs by limiting capital expenditures, and as a result, to limit nonprice competition. In fact, reducing duplication of hospital services is an explicit goal of the health planning legislation. Health planners see a reduction in this type of competition as an important tool with which to contain costs.

No studies have focused on competition per se, but CON review does not appear to have impeded nonprice competition. Because investments in bed supplies, equipment, and total assets do not appear to have been affected by CON review, there is no reason to conclude that, in the aggregate, CON review has reduced hospital competition.

Some believe that CON review has prevented construction of new facilities and in so doing has stifled potential competition from proprietary hospitals and from alternative health service delivery systems, such as HMOs. Although there is some anecdotal evidence that CON review has favored nonprofit hospitals over proprietaries, it has not been carefully tested.¹⁸ There is no evidence that CON review has impeded the development of HMOs.¹⁹

If changes were made in third-party reimbursement practices to encourage price competition among hospitals, however, CON review could be an obstacle to lower prices. Under conditions of price competition, if more hospitals offered a particular service, they would have an incentive to lower prices to attract patients. By limiting expansion of facilities and services, CON review could inhibit this type of price competition. Since there are currently few incentives for price competition, this is not a problem at present.

18. One study found that growth in the number of proprietary hospital beds was on average greater in those states with CON review than those without it. However, this result held only when three states (New York, Massachusetts, and Rhode Island) with relatively stringent CON programs and hospital rate-setting were excluded. See Policy Analysis, Inc., Evaluation of the Effects, vol. II, p. 295.

19. *Ibid.*, p. 330.

PROBLEMS WITH THE HEALTH PLANNING PROGRAM

Two types of problems may limit the success of the health planning program, particularly concerning cost containment:

- o Specific design and implementation problems that could be ameliorated through changes in the current health planning program; and
- o General problems that would be difficult to solve through program changes.

Problems Related to the Current Planning Program

Problems arising from the design and implementation of the current program include unclear goals, limited authority, conflicts with antitrust laws, uncovered projects, and limited benefits from process requirements.

Unclear Goals. It is widely thought that confusion about the mission of the health planning program has limited its effectiveness, or at least has hampered evaluation of its effects. Planning objectives vary across federal, state, and local agencies, among agencies at the same level, and within a single agency.

Statutory requirements and federal management have both contributed to this uncertainty. The planning act lists 17 wide-ranging priorities for the program, including cost control, improved access to services, quality of care, and efficiency in health-care delivery. Delays and changes in developing federal regulations and guidelines have also aggravated the situation. For example, federal guidelines for the development of standards were not final until 1978, although the act was passed in 1974.

An important facet of this confusion is that cost containment has been a much more important goal for the federal government than for most state and local agencies. Many state CON laws are intended to improve the distribution of health services rather than limit investment and total costs. HSAs often emphasize planning goals--developing preventive and primary services, for example--rather than the regulatory function of advising CON review decisions. On the average, less than 20 percent of HSA budgets are used for project review, including CON review. Over half

the budgets are allocated to plan development and implementation, data management, and public education.

Limited Authority. The limited authority of state and local planning agencies under the federal planning program is a serious obstacle to implementation of their health plans. HSAs and state planning agencies have no direct authority to enforce their health plans, but must rely on encouraging voluntary actions by health-care providers, state and local health agencies, and other community organizations. CON review is the only regulatory tool available, and it is a negative authority. Although planning agencies could sometimes influence the content of local grant requests because they were required, until recently, to review proposed use of federal funds for grant applications, they were not the decisionmakers. Similarly, HSAs were required to review the appropriateness of existing facilities, but had no authority to act on their findings unless a facility proposed to expand or replace its facilities or services. Planning agencies usually lack the authority to close unneeded facilities, and cannot require the development of needed ones.²⁰ They cannot take direct action to improve access to care for those who cannot afford it.

The inability to close facilities has particular implications for areas with declining populations. In urban areas that are losing population to nearby suburbs, excess capacity can result from the building of suburban facilities while the same level of operation in urban hospitals is maintained. At the national level, recent interstate population shifts imply that additional beds will be added in the growing southwestern states, while the Northeast will be left with increasing excess capacity.

Conflicts With Antitrust Laws. The potential application of antitrust action further limits opportunities for planning agencies to encourage voluntary cooperative actions by providers. Hospitals and planning agencies are less willing to participate in shared service arrangements because they fear legal action.

The activities in question include promotion of shared services, joint purchasing arrangements, and mergers, all of which

20. The 1974 Planning Act authorized funding for area health resources development, which was meant to be seed money used by HSAs to start projects and attract further financial support. No funds were ever appropriated for this purpose.

could be used to restrain competition. Some argue that when these activities are encouraged by planning agencies, hospitals should be exempt from antitrust action. But because no specific exemption was declared in the health planning act, courts have been reluctant to grant them. In a recent decision, however, the United States Supreme Court ruled that such exemptions may be made in some cases.²¹

Antitrust action is traditionally used against agreements among competitors that would lead to higher prices, but cooperative activities by hospitals could lead to lower costs--and potentially lower prices. These arrangements could hold down costs by allowing hospitals to take advantage of discounts in purchasing and eliminating the costs from duplication of underused services.

Uncovered Projects. In some states, CON laws do not require review of equipment or services that have low capital investment, but high operating costs, such as electronic fetal monitors or open heart surgery. Because hospitals can shift investments to uncovered areas, or substitute for capital other inputs that can increase operating costs, such as nursing care, the effect of CON review on total investments and hospital costs is weakened. To the extent that these investments would probably not have the same potential for increasing hospital costs as the disallowed expenditures, they would not be expected to make CON review totally ineffective in restraining growth in costs, however.

Limited Benefits From Process Requirements. Federal process requirements concerning the make-up of HSA governing boards and the comprehensiveness of the health plans have limited potential to improve the success of health planning and may even have negative effects. Compliance with the requirements for a consumer majority that is broadly representative of the HSA population does not ensure that the board will be representative of the community's values in health care, because these are based on factors other than race and income status and because the board is not accountable to the public for its decisions. Even if a governing board mirrors the area's population, the process of planning,

21. National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City, et al., No. 80-802, June 15, 1981. Although this particular decision appeared to rule against antitrust immunity for health planning, the decision states that such immunity may be granted in other cases.

which contains political elements, can still fail if participants lack commitment. Agency effectiveness may have suffered in some areas because community leaders with the potential to be effective in implementing agency goals have been excluded from participation because of federal requirements for a consumer majority. In addition, recruitment of board members who meet federal requirements absorbs agency staff resources and the time of the governing board.

Similarly, some local planners believe that federal requirements for developing a broad health plan absorb resources that could be used more effectively elsewhere. Although the content of the health plan is not a basis of federal approval, local agencies have felt the need to meet federal suggestions for content and format. This situation has been less true in recent years than it was in the early stages of health plan development, however.

General Problems With Health Planning

Problems that are related to the concept of health planning and would be difficult to solve by changing the structure or implementation of the current program include difficulties in developing and applying standards and with local planning, and costs of CON review.

Difficulties in Developing and Applying Standards. Unfortunately, much of the information necessary to define a population's need for health services is not available. First, detailed data on the health status of local populations often do not exist and would be very costly to collect. Second, little is known about the effects on people's health that changes in various health services would have. For example, the overall health benefits of establishing additional surgical facilities is unknown.

Although this problem exists for providers making independent decisions, it is not as serious for them as it is for planners. Unlike planners, providers are not attempting to coordinate services, and are not expected to present data publicly to justify their decisions.

Because of the lack of objective bases, development of standards is somewhat arbitrary. For example, federal guidelines set

a maximum standard of four general hospital beds per thousand population.²² The origin of the standard is a 1976 study by the National Academy of Sciences. This study determined that the national bed/population ratio was 4.4 and, citing general agreement that this level was excessive, recommended a 10 percent reduction to four beds within five years, with further reductions later.

As a result of these problems in developing standards, the standard can become the issue during the CON review process rather than the merits of the project. A hospital can argue, for example, that its obstetrics unit is needed, even if it would serve fewer patients than the standard requires.

The applicability of the bed standard is further complicated by varying definitions of "a bed." Hospital beds are usually counted in one of two ways. "Set-up" beds refer to those that are ready to be used. "Licensed beds" often are based on the square footage in the hospital to measure hospital bed capacity rather than available beds.

In addition, minimum use standards can encourage overuse of certain medical technologies. Under these standards, a facility that does not perform the minimum number of radiation treatments or surgeries, for example, will be considered unnecessary. Thus, hospitals and their physicians have a clear incentive to meet the minimum target.

Difficulties With Local Planning. Two problems related to local planning could limit successful cost containment: the lack of local incentives for cost control, and the potential for providers to dominate the planning process. The conduct of CON review at the local level presents an incentive problem because the costs associated with overinvestment are shared by a larger area, including those who use the hospital but live elsewhere, those who share in the higher health insurance premiums resulting from increased hospital costs, and federal taxpayers. Premiums are based on a group's expected use of health services and the expected costs of those services. If hospital costs increase, premiums

22. This standard can be adjusted upward if more than 12 percent of the population is elderly, if there are unusual and seasonal variations in hospital use, in rural areas, and within some parts of an HSA.

will rise as well. The federal budget absorbs a significant share of these costs through the Medicare and Medicaid programs and through the federal tax exemption for the employer-paid share of health insurance premiums. Because the benefits of additional services--such as perceived quality improvements, additional access, and community prestige--are concentrated in the local area and the costs are diffused, the tradeoff between new medical services and increased costs may not be clear to local reviewers. Although some decisions are made on the basis of cost containment, local planners could be expected to be better at directing resources toward additional services than at turning them down.

In addition to this lack of incentive, even well-intentioned consumer members of the CON review board can be susceptible to provider arguments for better quality care for their area. Hospital administrators and staff physicians are often respected members of the community, and have excellent credibility as a result. Consumer representatives on planning boards, who often have no prior experience with hospital issues, can find it difficult to judge arguments for approval by health care providers, especially when they are based on improving the quality of care. In some cases, hospitals may have advantages of information, expertise, and financial resources to expend in an application request that are not matched by the staffs of the planning agencies.

These problems are not as pervasive at state or national levels, because budgetary pressures provide an incentive for cost control. In 1980 the state government share of hospital expenditures for the Medicaid program was \$4.3 billion and federal Medicare and Medicaid payments comprised about one-third of hospital revenue. Private health insurance rates are generally determined by state-wide hospital costs as well, with the exception of premiums for multistate employers.

Local political pressures to approve new projects could affect state decisions, however. Although final decisions are made at the state level, state agencies often rely on HSAs to provide staff work for CON review, and most HSA recommendations are accepted, with state agencies changing only about 4 percent.

Costs of CON Review

The potential of CON review to contain costs is offset by the costs imposed by the process on participating facilities, although

the extent of these costs is not known at present. They include both application costs and costs from project delay.

Costs associated with the application process probably vary considerably across states, hospitals, and individual projects. They include preparation of the application and associated documents and staff time expended in the review process. Hospitals sometimes hire outside consultants to prepare applications. Estimates of preparation costs are difficult to assess because the activities resulting solely from CON review often cannot be separated from those that would have been performed anyway by the hospital in the process of planning capital projects.

Some analysts argue that the delay imposed by preparing for the review process and awaiting CON approval adds to project costs, but these claims may be overstated. During this period, the costs of the project adjusted for inflation probably will not change. While the hospital will have to provide funds to pay for any increased costs, it (or its donors) can earn interest on the equity capital to be used for the project, and do not have to pay interest on the borrowed funds until construction is underway. Because interest rates generally exceed the inflation rate, there will usually be no cost associated with this delay. There may, however, be some cases in which the price increase for the project does exceed the return from investment.



CHAPTER IV. OPTIONS FOR CHANGING THE HEALTH PLANNING PROGRAM

Four broad options are available to change the federal health planning program:

- o End the federal requirement for health planning and eliminate funding for it (Administration proposal);
- o Continue the federal role, either by maintaining the current planning program with modifications to increase the focus on cost containment, or by providing grants to those states that chose to have planning programs;
- o Offer funding for health planning in the context of a broad program of incentives to the states to contain hospital costs and;
- o Limit hospital investment by eliminating tax-exempt bonds for private hospital construction.

END THE FEDERAL ROLE IN HEALTH PLANNING (ADMINISTRATION PROPOSAL)

The Administration's proposal would end federal participation in health planning, as part of an overall strategy to increase competition in the health-care system and to decrease federal spending. Although the Administration has not yet presented a detailed plan, the general approach would encourage price competition among health service providers by increasing the patient share of medical payments, and by encouraging the development of less costly alternative systems for health service delivery, such as Health Maintenance Organizations (HMOs).

The first phase of this strategy, already adopted by the Congress, reduced the fiscal year 1981 appropriation for Health Systems Agencies (HSAs) by \$18.8 million from its previous level of \$101.7 million. The Administration wanted to eliminate HSAs entirely in 1982, but, under the continuing resolution (Public Law 97-92), the Congress funded HSAs at \$38 million. The Admin-

istration proposal for fiscal year 1983 would end the federal planning program, but allow states to continue certificate of need (CON) programs.¹

Probable Effects on the Health Planning Process

Recent surveys indicate that even without a federal requirement to do so, most states are expected to continue funding CON review.² They may do so in order to contain Medicaid expenditures for hospital care, or because they perceive positive effects on the distribution of health-care resources. These states would have to replace federal funds in order to maintain the program at current levels. Other states would probably choose to discontinue CON review programs because they oppose the regulatory approach, because they believe the program does not work, or because replacing cuts in federal funding for other programs would take precedence.³

Some state planning activities, in particular gathering data and preparing a state health plan, would be cut back or discontinued in many states. This loss of data might weaken state CON programs. Some state planning agencies expect more court challenges to future CON decisions that are based on outdated health plans.

Of those states continuing CON review, most would not continue to fund local planning, but little is known about many of the effects of this loss of local participation. HSAs vary in their activities, and their effects on the outcome of the planning process have not been measured.

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1. In contrast, The National Health Care Reform Act of 1981 (H.R. 850), introduced by Representative Gephardt, would not allow state CON laws to continue.
 2. Alpha Center for Health Planning, Alphawaves (October 1981); and Intergovernmental Health Policy Project, State Health Notes (George Washington University, December 1981).
 3. Some states passed CON legislation only to be in compliance with the federal planning law. Alabama and Arkansas, for example, passed CON legislation in 1981 with provisions for automatic repeal if the federal requirement were withdrawn.

Although local input could come from voluntary organizations other than HSAs in some areas, limited resources and the threat of antitrust action could limit their effectiveness. Private initiatives, such as health coalitions funded by businesses and insurance companies, might replace HSA review in some areas. The effectiveness of voluntary planning could be limited since these organizations might not have the resources to fund professional staff and data collection comparable to those of HSAs. In addition, hospitals and other providers would be even more reluctant to engage in mergers or other shared service arrangements under voluntary planning than under the current program. Although there is no explicit exemption from antitrust action under current law, the act does offer some protection.

Effects of the Administration's Proposal on Hospital Investment and Costs

The Administration's proposal would probably not have significant effects on aggregate hospital investment and costs, but could affect the mix and location of projects undertaken. Most states are expected to continue CON review. In addition, there is no evidence that CON review restrains growth in total hospital investment and costs, although studies of state CON programs are limited because they do not incorporate the effects of the 1974 planning act and because of technical shortcomings.

Some informed observers have argued that an end to the federal role in health planning would lead to a surge in hospital investment. They claim that the presence of a federal planning program has signaled hospitals to be cautious in their investment activity, despite the fact that the incentives for investment--third party reimbursement, competition for physicians and the availability of tax-exempt financing--have remained. A survey by the American Hospital Association indicated that many hospitals have a backlog of planned expansions.⁴ If the planning program were ended, these observers think that hospitals would carry out more of these projects.

4. American Hospital Association, Preliminary Report on 1979 Reimbursement Survey (June 1980, unpublished). The report indicated that about 21 percent of hospitals had expansion plans that had been discontinued or postponed.

Two factors may prevent this type of investment boom from taking place, however. First, those states that have perceived some success with CON review--and in which the likelihood of deferred projects is greatest--would probably not abandon it. At the same time, in the states with less effective CON review that would eliminate their programs, there would probably not be a significant backlog of investment plans to be implemented when CON review was removed.

Second, many financial analysts predict limited availability of funds for hospital borrowing, which would dampen an investment boom. Factors contributing to this limited borrowing capacity are high interest rates, recent federal income tax reductions that have reduced both the interest rate advantage of the tax-free bonds that hospitals use and the tax benefits of donations to hospitals, and the fact that many hospitals' balance sheets preclude a major increase in debt.

On the other hand, although an expansion in hospital investment is the less likely scenario, it would be costly if it took place. Increased reimbursement for operating costs as well as interest and depreciation would contribute to higher hospital costs, and higher Medicare and Medicaid outlays.

This option could lead to changes in the types of investments made in those states that repeal CON review. Even if total investment has not been affected, some applications have been altered, withdrawn, or denied as a result of the review process. Consequently, in the absence of a CON program, some investments would be made that had not been made with CON review. Hospitals would no longer have to tailor their investments to match planning agency goals concerning project types and locations. The impact that these changes in the types of investments would have on quality and access to care is unknown.

Potential Effects on Competition

The Administration's proposal to end the federal role in health planning would not have significant effects on competition among hospitals in the short run. There is no evidence to indicate that CON review or other planning activities have impeded competition.

Competition from HMOs could be restrained, however. The 1979 Amendments to the Health Planning Act require that HMOs be exempt from CON review under certain circumstances. Some states are not in compliance with this requirement, however, and with the termination of the federal act, more states continuing CON review might eliminate this exemption for HMOs, thus lessening competition from these lower-cost alternative health service delivery systems.

Finally, it is important to note that some planning agency activities can be complementary to competition. Many HSAs have been involved in direct efforts to stimulate competition, such as assisting in developing HMOs in their areas or publishing physician fee information. Other nonregulatory planning activities, such as identifying needed services, improving access to care, and encouraging preventive health care, for example, would not conflict with efforts to foster price competition. In addition, the data collected by planning agencies could be useful in implementing a competitive strategy.

CONTINUE A FEDERAL ROLE IN HEALTH PLANNING

A second option would continue a federal role in health planning. This could be done by continuing the current program with modifications to increase the focus on cost containment, or by offering federal grants to those states that choose to maintain planning programs.

One reason for supporting this option is that the effectiveness of the federal health planning program in fostering cost containment has not been adequately evaluated. In addition to having technical flaws, evaluations of CON review have focused on the experience that either preceded the 1974 act, or occurred too soon after to have been influenced by it.

A second reason is that, because the federal government benefits from any successful planning efforts, it should share in the funding of these programs. Although studies have not found significant aggregate effects of CON review on reducing hospital costs, to the extent that some states are successful, the federal government benefits by reduced Medicare and Medicaid outlays--about 32 percent of any cost reduction.

It is not known, however, whether savings from continuing a federal role would exceed the costs of funding the program. Studies have not found evidence that CON review reduces costs, but because the planning program is relatively inexpensive, the effects necessary to achieve federal savings that cover the costs of the program are small--possibly too small to have been isolated in econometric studies. For example, in fiscal year 1981, the savings necessary to cover the federal costs of the health planning program amounted to less than 0.2 percent of total community hospital expenditures. This small an effect may fall within the range of statistical error in the analyses of CON review.

A third reason for maintaining a federal role in planning relates to the distribution of services rather than cost containment. Hospitals with the best financial situation would have the easiest access to funds, regardless of how well their investment projects reflected local priorities, a problem that could be exacerbated by the predicted tight credit market for hospitals. In addition, the cutbacks in data gathering and analysis expected without federal funds would weaken the information base used in CON review to determine which projects are most needed.

Continue Current Policy with Program Modifications to Emphasize Cost Containment

One option to continue a federal role in health planning would maintain the current health planning program, but make changes to focus agency activities on cost containment. This approach would attempt to strengthen the program by addressing directly the problems of unclear goals and burdensome federal requirements that might have limited the effectiveness of health planning in containing costs.

On the other hand, federal program changes might not increase the success of CON review in states that do not have a strong commitment to cost containment. In addition, some of the activities at which planning agencies have been successful would probably be abandoned if cost containment were the single focus.

Modifications that might increase the effectiveness of health planning in restraining growth in hospital investment and costs include:

- o Make cost containment the major program goal;
- o Change CON review requirements;
- o Alter federal process requirements;
- o Consolidate HSAs or planning functions; and
- o Grant an antitrust exemption.

Make Cost Containment the Major Program Goal. Local agencies might be more effective in containing costs if the priorities stated in the planning act were altered to reflect an explicit federal emphasis on this goal. The current broad mandate has led many agencies to spend most of their resources on other activities.

Change CON Review Requirements. Some changes in the CON review requirements might make the process more effective by targeting review only on those projects that have potentially high costs. These changes could include raising the dollar thresholds for review of capital, equipment, and services spending, and excluding from review proposed projects that do not involve medical services, such as parking garages.

These changes--some of which are already being made in some states--would reduce the number of proposals reviewed, and allow for more careful consideration of those projects that would have the most potential to affect hospital costs. The staff resources needed for CON review might also be reduced, and hospitals would save by having to prepare fewer CON applications.

Alter Federal Process Requirements. Federal process requirements could be changed, including those to prepare comprehensive health plans and those to ensure representative membership on the planning board. The Congress recently took a step toward reducing federal requirements by allowing the Secretary of Health and Human Services to waive the requirements for proposed use of federal funds and appropriateness reviews (Public Law 97-35).

If the federal requirements for broad local health plans were changed, HSAs would be able to focus on cost-containment issues only. Some HSAs argue that staff resources devoted to developing plans to meet the broad requirements of the planning act could