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## Hospital Planning: What Happened to California's Certificate of Need Program?

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*Requested by Assemblymember Wilma Chan  
Chair of the Assembly Health Committee*

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## EXECUTIVE SUMMARY

This report responds to a request from Assemblymember Wilma Chan, Chair of the Assembly Health Committee, to research what happened to California's hospital certificate of need (CON) program. For over 30 years, the state and local planning agencies were involved in analyzing and approving the construction and expansion of health care facilities and services, based on a determination of community need. The goals were to ensure access to quality health care and to contain costs by restricting excess hospital capacity. This report discusses the history of California's CON program as well as key findings from other states.

When California's first CON program was enacted in 1969, health care consumed about six percent of the gross domestic product (GDP), an increase of about one percent since 1960; it now consumes over 14 percent and is projected to reach about 17 percent by 2010.<sup>1</sup> During that time the medical marketplace in California has changed significantly. Most notably, fee-for-service pricing has been largely replaced by managed health care services based on a fixed fee per patient.

California suspended its CON law in the mid-1980s at a time of federal deregulation. However a number of states took a different approach and strengthened their programs; 37 states currently have CON laws.

A number of studies challenge the assumption inherent in CON laws that restricting the supply of health care facilities reduces health care costs—in fact, they contend, it increases costs by restricting competition.<sup>2</sup> In contrast, CON supporters assert that regulation has a positive effect on hospital capital expenditures and health care costs,<sup>3</sup> compensates for imperfections in the health care market and promotes access and quality health care.<sup>4</sup>

Whether a CON program is effective depends in part on its statutory and staffing structure. California's CON program appears to have suffered from inadequate staffing and lack of data. In addition, there were a number of exceptions to the program that made it difficult to administer, and sanctions for noncompliance were infrequently utilized. Other states, notably North Carolina and Michigan, apparently have effective, well-staffed CON programs. Their impact on reducing health care costs has not been demonstrated, however.

One economic analysis concludes that the underlying economics of the health care industry make it possible for regulators to avoid costly excess hospital capacity. The key variable is implementation:

How successfully regulators can actually control hospital capacity to reduce costs will turn out to be strictly an empirical question, because the theory tells us that they could either help things out or goof things up.<sup>5</sup>



## INTRODUCTION

Hospitals in the United States date to colonial times. The oldest hospital in the country, Philadelphia General Hospital, was originally established as a public almshouse in 1732. In 1751, the Pennsylvania Hospital was incorporated to offer care for the physically and mentally ill without regard to economic status, race or creed. Other early hospitals were established to offer clinical practice for medical schools.<sup>6</sup>

The hospital is central to community health care.

It is an integral part of a social and medical organization, the function of which is to provide for the population complete health care, both curative and preventive, and whose out-patient services reach out to the family and its home environment; the hospital is also a centre for the training of health workers and for bio-social research.<sup>7</sup>

During the Depression and World War II, few hospitals were built in the United States and maintenance was postponed, creating an unmet need, particularly in rural areas.<sup>8</sup> In 1947, the Hill-Burton Program authorized federal grants to states for surveying, planning, constructing and equipping public and nonprofit hospitals and public health centers, and required states to develop a comprehensive state plan to develop *needed* health care facilities in order to apply for funds.

### THE CONCEPT OF NEED AS A BASIS FOR REGIONAL HOSPITAL PLANNING

A 1947 forum convened by the American Hospital Association considered how to define unmet community “need” when planning new hospital facilities. The concern was that if hospitals independently planned their facilities, the fragmented planning process would result in costly duplication that could drive up health care costs. Speakers at the forum advocated for broader community planning efforts. Determinations of community “need” would be based on hospital bed occupancy rates, birth and death rates, population growth and length of stay, among other variables that could serve as guides to achieving an efficient allocation of health care resources.<sup>9</sup>

Regional hospital planning is based on the premise that the cost of building and operating a hospital should be considered in the context of total community needs and limited health care resources. Hospitals require long-term capital investment. They are very costly to build and operate and need skilled personnel. Once a hospital has been built and staffed, its beds are likely to be utilized.<sup>10</sup> Patients whose medical needs might be served more inexpensively in another type of facility or at home may instead be admitted to a hospital. Other elements of community care, such as preventive care and health education, might be more cost effective. A balanced plan seeks to ensure an appropriate mix of health care facilities in a region.

A 1968 report by the World Health Organization (WHO) describes the following benefits of regional hospital planning:<sup>11</sup>

- A better and fairer distribution of services
- A reasonably uniform standard of medical care
- Economies of scale through centralization of purchasing and business functions
- Better utilization of facilities and of expert advisory services, such a medical care specialists, and of specialized care units (such as for severe burns) and equipment

The WHO report describes the principal function of a regional health care planning agency as establishing, in broad terms, the range of services that each hospital should provide in a regional master plan. This requires a regional analysis of health services facilities and major equipment, as well as forecasts of future demand based on projected changes in population, the regional economy and medical practices.<sup>12</sup>

## **MARKET FORCES AND HOSPITAL CONSTRUCTION**

Over the forty year period surveyed in this report (roughly 1947 to 1987), the nation's health care market and views toward government regulation and hospital planning changed. Certificate of need (CON) laws enacted in the 1960s and 1970s required a hospital to seek permission (a certificate of need) from regional and state agencies in order to expand capacity. Over time, the following question was increasingly posed by the industry and some policymakers:<sup>13</sup>

The fundamental logic of CON controls rests on the premise that natural market forces will lead to 'too much' hospital capacity, with undesirable economic consequences. Does any economic rationale exist for this belief?

The history of California's CON program presented in the next chapter charts the evolution of state policy from planning and regulation to deregulation. A number of states continue to have CON programs, and these are discussed in the final chapter of this report, along with a summary of the relatively few studies that empirically examine the impact of CON programs on health care costs.

## HOSPITAL PLANNING IN CALIFORNIA

### FEDERAL POLICY—THE HILL-BURTON PROGRAM

The Hospital Survey and Construction Act of 1947 (PL. 79-725) created the Hill-Burton Program, authorizing federal grants\* to states for surveying, planning, constructing and equipping public and nonprofit hospitals (including general, mental, tuberculosis, chronic disease and public health centers). In order to access this infusion of federal resources, states were required to survey existing hospital and public health center resources, and to develop a comprehensive state plan with the goal of furnishing adequate hospital, clinical and other health care facilities. The Act specified a 4.5 to 5.5 general hospital bed/1,000 persons ratio as the upper limit for federal aid. This bed/population ratio became an accepted standard of adequacy or need for health care facilities.<sup>14</sup>

Over time the Hill-Burton Program was expanded to include nursing homes, diagnostic and treatment facilities, rehabilitation facilities, and chronic disease facilities (1955), to fund facility modernization (1964), and to emphasize outpatient facilities and increase financial assistance to poverty areas (1970). States created federally required regional and statewide planning structures to be eligible for federal funds.

In 1963, the Public Health Service developed a revised formula to determine the need for new health care facilities based on population, hospital utilization<sup>†</sup> and an 85 percent occupancy rate. A later review by the Comptroller General found that this might not have been a realistic assumption, given that average occupancy rates varied from 66 percent to 81 percent, depending on the size of the hospital. As a practical matter, the higher occupancy rate restricted the amount of health care facility expansion that was eligible for federal funding.<sup>15</sup>

Amendments to the federal Hill-Burton Program in 1964 strengthened hospital planning efforts by allowing 50 percent in matching federal funds to be used for public or nonprofit voluntary regional planning groups. In 1966, the federal Comprehensive Health Planning Act reaffirmed the importance of health care planning, establishing a new planning program based on a partnership between government, providers and consumers. It required a single state agency for health planning, and regional health planning agencies, with a consumer majority on all planning councils.

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\* The grant formula required one-third federal funds, one-third state funds and one-third facility funds.

† Hospital utilization is affected by a number of factors including the availability of beds, payment methods, age of the population, service coverage and geographic distribution, availability of other medical services, shortages of personnel, space or equipment, medical and social customs, supply of physicians, research and training, housing, morbidity patterns, and internal organization. See R. Llewelyn-Davies, H.M.C. Macaulay, *Hospital Planning and Administration*, World Health Organization, Geneva, 1966, pp. 32-35.



## **EARLY CALIFORNIA STATEWIDE HOSPITAL PLANNING EFFORTS**

California was an early participant in the Hill-Burton Program, enacting the California Hospital Survey and Construction Act of 1947, which created the State Hospital Advisory Council in the State Department of Public Health. The Council's purpose was to develop an annual state plan, which estimated the need for medical facility construction based on an inventory of existing beds and services. On the basis of this analysis, areas in the state were assigned priority ranking for grant funds to construct or remodel hospitals. The state Act defined "hospital" as follows:

... hospitals for the chronically mentally ill and impaired, public health centers, community mental health centers, facilities for the mentally retarded, and general, tuberculosis, mental and other types of hospitals and related facilities, such as laboratories, outpatient departments, nurses' home and training facilities, and central service facilities operated in connection with hospitals, diagnostic or treatment centers, nursing homes, and rehabilitation facilities, but except for facilities for the mentally retarded does not include any institution furnishing primarily domiciliary care.<sup>16</sup>

Over the first decade of the program, there was considerable unmet need for hospitals in the state and planning was rudimentary.<sup>17</sup>

The Governor's Committee on Medical Aid and Health examined California's health needs in 1960 and found that "Lack of coordinated planning has resulted in duplication and inappropriate use of expensive services and facilities, gaps in essential services, competition, and overbuilding in some areas, and underbuilding in others."<sup>18</sup> There were 9.5 hospital beds (of all types) per 1,000 persons in California, compared to 7.5 in the nation as a whole. The committee concluded that the state had excess capacity, and recommended a goal of 7.5 hospital beds per 1,000 persons along with the development of less expensive community programs for home care and rehabilitation.<sup>19</sup> The committee also recommended the creation of a State Health Council and regional health councils with the power to deny or revoke the licenses of health care institutions that failed to comply with regional plans.<sup>20</sup>

### **Voluntary Regional Planning Agencies**

In 1961, the California legislature enacted a Governor's Committee's recommendation (AB 2983, 1961) and created two voluntary regional hospital planning committees (one for southern California and one for the San Francisco Bay Area). In 1963, a voluntary regional hospital planning committee was also created for the south San Joaquin Valley (SB 564, 1963). The State Hospital Advisory Council appointed members of the regional committees, a majority of which were required to represent consumers.

The regional planning bodies were charged with developing principles and standards of community need and compiling baseline information about existing facilities. They presented the following rationale for regional hospital planning:<sup>21</sup>

... the uncoordinated development of hospitals and related health facilities and services has created problems of duplication, overlapping and inappropriate size and location of facilities .... The mounting cost ... imposes a needlessly heavy financial burden upon consumers .... Many hospitals and related health facilities are currently of inappropriate size and location because there has been a lack of community planning.

A 1962 report to the Hospital Planning Council of the Sacramento Metropolitan Region offers an example of a community-wide health facilities planning process. In the report, consultants assessed the future need for facilities based on past usage patterns and expected population growth, projecting the estimated shortage of hospital beds over a 20 year period. Taking into consideration existing facilities and their geographical distribution, the consultants recommended a phased program of expanding existing facilities and building four new hospitals over the following 20 years.<sup>22</sup>

However the demand assumptions on which this planning was based became obsolete in 1965, when Congress created the Medicare medical insurance program for persons over 65 and the Medicaid medical insurance program for medically indigent persons. These programs substantially increased consumer demands on the health care system.

In 1965, California's legislature enacted Medi-Cal as the state's Medicaid program, and included a reimbursement formula requiring that new hospital construction be approved by voluntary regional planning groups. That same year, on the recommendation of the three voluntary regional health services planning agencies,<sup>23</sup> the legislature created the Hospitals and Related Health Facilities and Services Planning Committee to promote statewide planning for health facilities and standards (SB 543, 1965).

A 1965 national review of state hospital advisory councils cited California as a model, because the council held regular, public meetings that were well attended and determined which projects were to receive Hill-Burton funds. This was because the director of the Department of Public Health chaired the advisory council and generally followed its advice.<sup>24</sup> In some states, hospital advisory councils were virtually inactive.

The state's Hospitals and Related Health Facilities and Services Planning Committee released a legislatively-mandated report in 1968, after three years of examining "... in greater depth the problems and possible solutions in planning for a continued high quality of health care through better organization of resources ..."<sup>25</sup> Despite earlier legislative requirements that voluntary regional hospital planning agencies define standards of community need and compile baseline information, the committee found that "... well-defined planning criteria are virtually nonexistent."<sup>26</sup> Regional planning agencies lacked sufficient staff to undertake their responsibilities, such as surveying local health care facilities. No regional body had developed a plan for all of its hospitals or projected future needs, and even the definition of region had generated local controversy.

The committee found that in general hospital mergers, coalescence of services, and development of prepayment health plans had occurred outside of the regional health care planning process. The advice of voluntary regional health planning agencies to not build

or expand facilities had been ignored in some instances, since they had no real authority to enforce their recommendations. Outcomes tended to be negative—preventing facility construction—rather than positively supporting needed construction and expansion. Hospitals, community groups and unions, among others, were not pleased with this outcome.<sup>27</sup> Nonetheless, although it found it “impossible” to estimate savings, the committee asserted that planning had saved “immense” sums of public and private money by preventing “ill-conceived” facilities.<sup>28</sup>

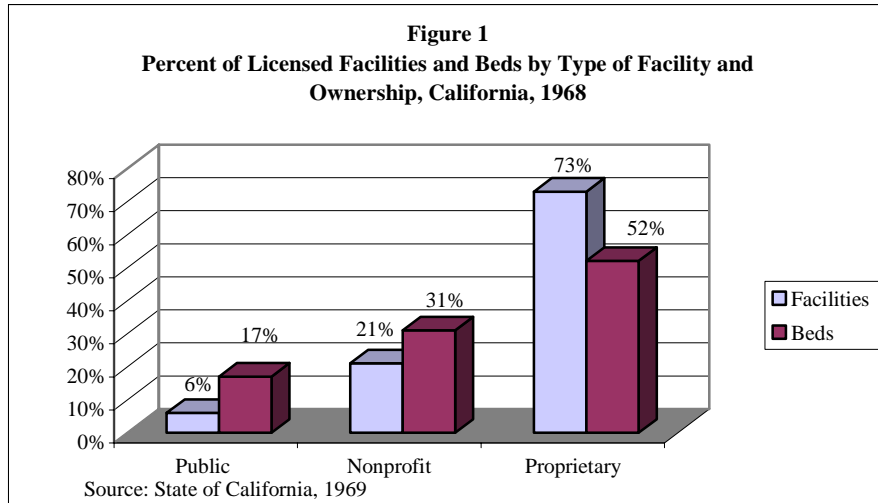
The committee concluded that consumer representation on the state’s voluntary regional planning bodies had improved the planning process, and recommended continued public financial support for local and regional health planning efforts, expanded training for health care professionals, improved data collection, and the denial of some Medi-Cal reimbursement for uncooperative health facilities that ignored regional planning recommendations.<sup>29</sup>

A 1967 study found approximately 75 regional hospital and health facility planning councils in the country, covering about half of the nation’s population. After interviewing staff at about half of the councils, the author concluded that they emphasized process over data and technical procedures, relying principally on interaction between “...major business and industrial interests, the major health providers, and the council planners for purposes of self interest and health services development.”<sup>30</sup>

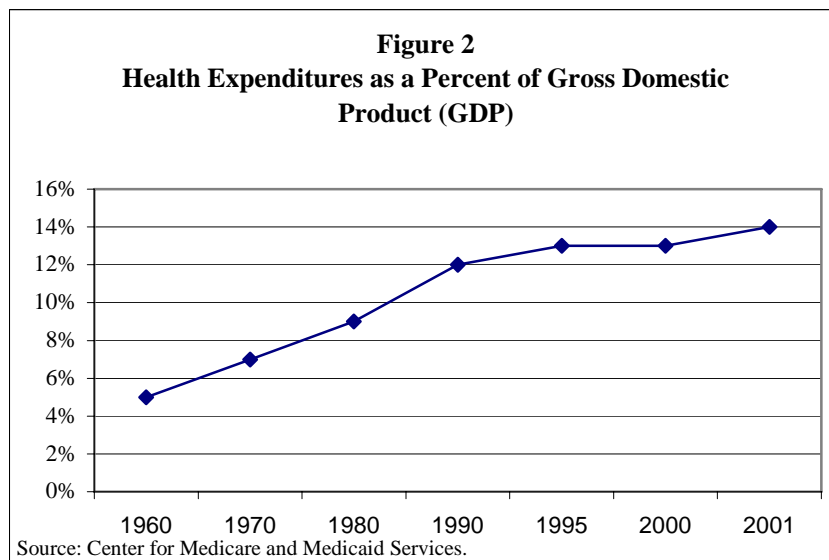
In 1968, California had nine voluntary regional health facilities and services planning agencies\* encompassing 52 counties and 98 percent of the state’s population. The state had about 2,400 health facilities with approximately 165,000 beds (see Figure 1).<sup>31</sup> Facilities housing more than 60 percent of the state’s hospital beds had been built since 1947, when the Hill-Burton Program was enacted; the program had funded about 18 percent of those facilities.

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\* The voluntary planning agencies included the North Coast Health Facilities Planning Association, Inc., the Superior California Comprehensive Health Planning Association, the Hospital Planning Council for Sacramento, Yolo and Placer Counties, the Bay Area Health Facilities Planning Association, the North San Joaquin Valley Regional Health Council, the Regional Health Planning for South San Joaquin Valley, the Health Planning Association of Southern California, the Comprehensive Health Planning Council of San Diego County, and the Health Facility Planning Council of Imperial County.



In 1968, health care consumed about six percent of the gross domestic product (GDP), an increase of about one percent since 1960; it now consumes over 14 percent and is projected to reach about 17 percent of GDP by 2010.<sup>32</sup>



## THE CERTIFICATE OF NEED PROGRAM

Certificates of Need (CON) are regulatory tools for reviewing and approving or disapproving certain kinds of capital expenditures for health facilities as well as the provision of some new services (such as organ transplantation). In states with CON laws, health care providers cannot initiate construction without a CON issued by the state; approval requires a finding of community need, based on established planning criteria.<sup>33</sup>

New York was the first state to adopt a CON law, for nursing homes, in 1964. In 1969, California enacted its first CON program (AB 1340, 1969) for health facilities including acute general hospitals, skilled nursing facilities, acute psychiatric hospitals, intermediate

care facilities, and the conversion of existing beds to a different type of service. The goal was to provide real authority to the regional health planning agencies. If, for example, a regional health planning agency determined that a proposed facility did not meet the needs of the community based on existing rates of utilization, it could deny a certificate of need. If a facility proceeded contrary to a certificate of need decision, Medi-Cal payments could be withheld.

From 1970 to 1973, about 14,000 additional beds for California health facilities were approved for a CON, and nearly 15,000 were denied.<sup>34</sup> When federal Hill-Burton standards of need were applied, the state had considerable excess hospital bed capacity.<sup>35</sup> Some regional planning agencies had approved license applications for construction, expansion and modernization in areas for which the statewide plan showed no need and, as a result, the state agency turned down some applications for federal funds.<sup>36</sup>

According to a later state analysis, weaknesses in the state's 1969 CON program included a lack of uniform statewide standards and too many exceptions (for example, 39,000 beds were "grandfathered" and modernization and relocation of facilities were exempted).<sup>37</sup> The sanction of withholding Medi-Cal payments was little used. In addition, regional planning agencies lacked adequate information on which to base their decisions. In 1971, the legislature required hospitals to provide uniform accounts of their health services costs for public disclosure (SB 283, 1971), in part to assist in the planning process.

The Social Security Amendments of 1972 authorized federally financed state reviews of the capital expenditures proposed by health care facilities (a "section 1122" review). Projects built without state approval could be denied reimbursement for interest and depreciation related to the capital expenditures under Medicare, Medicaid and the Maternal and Child Health Programs. California opted to not participate, thereby neglecting a tool that might have strengthened its CON program.\*

Despite the Hill-Burton requirement that a state's health care facilities plan be updated annually, a 1974 review by the Comptroller General of the United States found that California had last surveyed its general hospitals in 1965, and that some nursing homes had never been surveyed. State officials contended that they did not have sufficient personnel or financial resources and that they focused instead on applications for new construction or modernization, and surveyed facilities in those areas to determine need.<sup>38</sup>

In 1974, the National Health Planning and Resources Development Act (PL 93-641) revised and extended the Hill-Burton Program to authorize grants, loans and loan guarantees to health care facilities for modernization, construction, conversion and/or elimination or prevention of safety hazards. The Act also provided increased funding for planning, and required more coordination between state and local health planning agencies. The states were required to have a Medical Facilities Plan and a CON program approved by the Secretary of Health, Education and Welfare by 1980, as a condition for receiving federal funds. In advocating for the legislation, the Secretary of the Health,

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\* As of July 1, 1986, 15 states had a section 1122 program.

Education and Welfare Agency asserted that "... the comprehensive health planning system is beset with weaknesses that interfere with its effectiveness." Nonetheless, he argued that.<sup>39</sup>

...the evidence is persuasive that unconstrained health resource development, particularly of inpatient facilities, contributes significantly to the problem of excessive and unnecessary increases in health care costs. The lack of effective competition, the dependence of patients on the judgment of their physicians regarding their health care needs (and the consequent capability of supply to generate its own demand), the predominance of cost reimbursement as a means of paying for institutional care services, and pressures for institutional aggrandizement in a noncompetitive economy, combine to offset normal competitive constraints on building excess supply.

### **Assembly Health Committee Interim Hearings**

In October 1975, the California Assembly Health Committee held hearings on proposed state legislation to create a CON program, as required by the National Health Planning and Resources Development Act. In his opening statement, the committee chair asserted that the cost of health care services was a matter of "serious public urgency," with the average cost of an acute care bed in California 40 percent higher than in the nation as a whole. He noted that the cost of hospital care was the single largest component of health care costs, and estimated that ten percent of that cost was due to excess bed capacity. Government paid 40 percent of all hospital costs.<sup>40</sup>

The committee heard testimony that decisions about which hospitals were to receive Hill-Burton funds had been made independently from the general needs assessment established by regional planning agencies and in the state plan.<sup>41</sup> The Chief of Health Planning for the Department of Health informed the committee that statutory exceptions to the state's CON program substantially decreased its effectiveness. He characterized the industry in California as suffering from "... poor utilization, improper location and needless duplication of health facilities and services."<sup>42</sup> There were 9.7 licensed beds per 1,000 population in 1974, and general acute care hospitals were on average only 62 percent occupied. Since Medi-Cal allowed hospitals reimbursement for the cost of maintaining unused beds, the state effectively underwrote unused capacity.

### **AB 4001**

In 1976, California enacted legislation (AB 4001, Chapter 854, Statutes of 1976) creating a stronger CON program. The new Office of Statewide Health Planning and Development (OSHPD) in the Department of Health was made responsible for administering the program, with actual decision-making authority over proposed health facilities projects. The decisions of the state's 14 regional health planning agencies were advisory in nature. Projects undertaken without a CON or an exemption issued by the department were subject to denial or revocation of license, civil penalties and mandatory denial of Medi-Cal reimbursement. Appeals were made to the State Health Advisory Council.

In a manual intended for volunteers serving on local planning agencies and for members of the public, OSHPD described the need and purpose of the CON review process as guiding the development of needed health facilities, services and medical equipment, while preventing "... the addition of unnecessary duplication of health facilities, services and medical equipment."<sup>43</sup>

According to the OSHPD manual, there were 88,000 hospital beds in California in 1975, of which 23,000 were empty at a cost of \$420 million (\$2.17 billion in inflation-adjusted dollars). OSHPD's explanation for this situation was that "Health facilities through construction and modernization increased their bed capacity at such a rapid rate, that the number of beds per population rose and outpaced the moderate increase in hospital usage, thereby resulting in a declining rate of occupancy."<sup>44</sup> Since over 90 percent of the payments for hospital care were made by government or private insurance companies, the increased cost of hospital care (which rose 15 percent from 1975 to 1976) seriously impacted "... the people who pay for their own health care and who must also pay for others by way of taxation ...."<sup>45</sup>

The state's CON program applied to the following activities:<sup>46</sup>

- construction of a new health facility
- increase in bed capacity in an existing facility
- conversion of a health facility from one license category to another
- conversion of existing beds to a different classification, such as from skilled nursing to general acute care
- establishment of special services requiring licenses such as burn centers
- initial purchase of diagnostic or therapeutic equipment and other capital expenditures valued over \$150,000
- establishment of free-standing surgical clinics and chronic dialysis clinics

Applicants paid a fee based on the type of facility and the expected cost of the project.

There were a number of exemptions to the CON program, including for comprehensive group practice prepayment health care service plans (Kaiser), and health care facility remodeling and replacement. Additional exceptions were enacted in 1977 (AB 245). According to a former OSHPD official, these "loopholes" made the program difficult to administer. The program was criticized by the hospitals, and suffered from declining legislative support.<sup>47</sup>

The CON program was strengthened in 1979, when Congress amended the Health Planning and Resources Development Act, requiring CON review and approval of capital expenditures and major medical equipment purchases exceeding \$150,000 and of health care services over \$75,000.<sup>48</sup>

## DEREGULATION

President Reagan's *Omnibus Budget Reconciliation Act of 1981* substantially reduced federal funding for health care facilities planning, and provided governors the option of terminating federal funds for local health planning agencies. Eleven states exercised this option. Reasons for discontinuing local health planning agencies included the general perception that regulatory agencies were out of favor, provider dissatisfaction, poor local planning efforts, duplicate local-state regulation, and a desire for statewide uniformity.<sup>49</sup> The President's budget requests for fiscal years 1982-1986 proposed repealing the entire CON program to "... reduce the regulatory burden on the private sector."<sup>50</sup> In 1986, Congress repealed the legislation mandating state CON laws (Pub. L. No. 99-660, 100 Stat. 3743, 3799).

In the mid 1980's, a number of states—including California—abandoned the CON process. Changes in the health care market, as well as declining federal and state support for health care facilities planning, were key factors. In October 1983, Medicare (which pays for one quarter of all hospital admissions) switched from a cost-based, dollar-for-dollar fee-for-service payment system to paying each hospital a flat amount for a given category of admissions. Doctors and hospitals were confronted with a fixed budget for the care of each patient, altering incentives and introducing "... a cost-consciousness that had been notably absent previously."<sup>51</sup> As one result, the amount of time a patient stayed in a hospital ("length of stay") declined over 21 percent on a yearly basis from 1984 to 1988, an unusual one-time decline. Use of skilled nursing facilities and home health care increased by over 25 percent.<sup>52</sup>

In California, the change in Medicare pricing "... coincided with a large increase in the market share of cost-conscious private health insurance as well as a shift to competitive bidding for the state's Medicaid hospital business." Inflation-adjusted hospital costs in the state decreased by over 11 percent from 1983-1985, a historically unusual event.<sup>53</sup>

In 1983, the California legislature enacted legislation providing a number of exemptions to the CON program (Statutes of 1983, Chapter 1105). In 1984, the legislature indefinitely suspended the CON program as of January 1, 1987 (Chapter 1745 § 439.7, Statutes of 1984), instead of repealing the program, which might have affected federal funding. Federal documents list California as having a CON program in 1986, but with no real criteria.<sup>54</sup>

In 1993, the legislature authorized counties to eliminate or consolidate health planning advisory boards required by state law or regulation (Statutes of 1993, Chapter 64 § 2). In 1995, the legislature repealed the Health and Safety Code provisions addressing hospital construction and health planning (Statutes of 1995, Chapter 415 § 791). California currently does not engage in hospital planning at the state or regional level.





## CERTIFICATE OF NEED PROGRAMS IN OTHER STATES

A number of states took advantage of federal deregulation to restructure and redefine their health planning programs in the 1980s. They strengthened local planning agencies and established uniform statewide procedures to reduce duplication in the state-local review process. State funding replaced federal funding.<sup>55</sup>

- In Florida, a new state-run, state-supported health planning structure composed of 11 local health planning councils was created in 1982. The local councils developed district plans, which together served as the basis for state CON rules, but they no longer made specific recommendations on CON project applications from their districts.
- In New York, the Governor's Health Care Policy Advisory Committee recommended a one year moratorium on CON applications, so that all providers in the state could develop five-year capital outlay expenditure plans. With state financial support, local health planning agencies used this information to develop area medical facilities plans that were aggregated into a statewide plan. The plans established the concept of relative need for capital outlay projects.
- Ohio created a Statewide Health Coordinating Council in 1982, and allowed some of its local agencies to close, relying instead on a network of voluntary business and community organizations.
- Washington State reaffirmed its commitment to local health care planning, providing direct state financial assistance to local agencies for CON analysis. The state continued to make final CON decisions, based on criteria drawn from a coordinated state/local planning process.

Thirty seven states currently have CON programs.\* Their comprehensiveness varies considerably by state, by the types of facilities that are regulated, the level of cost threshold requiring review, and the criteria and standards for review.<sup>56</sup> There does not seem to be consensus as to their effectiveness. As one analysis points out, "Regulation, re-regulation, and deregulation of hospital services are occurring simultaneously today in various areas of the country."<sup>57</sup>

In general, state CON laws specify the number of hospital and nursing home beds or large specialized devices such as MRIs allowed in any region. In order to expand capacity, an organization must receive permission from state regulatory authorities, some of which delegate considerable discretion to regional planning agencies. Need for

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\* The American Health Planning Association conducts an annual survey of all 50 states and the District of Columbia and compiles the information in its *National Directory, Certificate of Need Program, Health Planning Agencies*.

additional capacity is determined by complex formulas and disputes are resolved through formal legal structures, sometimes including formal trials.<sup>58</sup>

The State of Washington is currently reviewing its CON program and conducting a national review of state CON efforts. The following comments are taken from the Washington State review:<sup>59</sup>

- In Maine, CON has become “... part of a promising larger effort to control the costs of health care and to expand health insurance coverage to the uninsured.”
- In Michigan, the approach has been “... to regulate the utilization of facilities and equipment and the location of services using a consistent measuring tool for each.”
- In Ohio, CON jurisdiction is restricted to long-term care; after deregulation “...the ensuing explosion in capacity, particularly in physician-owned services, created considerable excess capacity and escalation in costs.”
- In Vermont, a 2003 reform of CON laws found that “... the main lesson learned was that the resources available to the regulators must meet the needs of the state for oversight and regulation.”

A consultant summarizing state CON programs for the Washington State review ranks North Carolina and Michigan as having the most effective programs; his comments are summarized below:<sup>60</sup>

- Key elements of the North Carolina CON process include development of an annual plan by a well-staffed state council with considerable public input, following clear statutory standards of “need;” these become “determinative limitations” on what may be approved for development. The state Department of Health and Human Services may withdraw a CON if a project fails to develop and operate consistent with the CON. The result has been broad geographic access to all but the most complex services and reduced health care costs due to “... limited development of specialty hospitals, free standing ambulatory surgical centers and diagnostic centers as well as acute care, psychiatric, nursing and assisted living beds.”<sup>61</sup>
- Michigan regulates a selected set of high-impact facilities and services such as hospital and ambulatory (outpatient) surgery services. CON applicants must demonstrate that a service is needed, not duplicative, and will be provided at the least cost. The CON process is well organized and staffed at the local and state levels. The hospital association and business community are very involved and supportive.

## EFFECTIVENESS OF CON IN CONTROLLING HEALTH CARE COSTS

In evaluating CON programs, some analyses have focused on implementation, particularly the effectiveness of state legal structures and administrative processes. Other studies have considered the extent to which CON programs have contributed to controlling health care costs; we present findings from some of those studies in this section.

Hospital spending is clearly an important driver of health care costs. A review of health care costs in 2002 found that “Hospital spending continues to drive overall health care spending trends, fueled by rising hospital price inflation.” Growth in hospital spending accounted for 51 percent of the overall increase in health care spending in 2002, which increased 9.6 percent per person in the United States.<sup>62</sup>

Studies also find a relationship between technology and health care utilization and spending. A study published in *Health Affairs* found that “... increases in the supply of technology tend to be related to higher utilization and spending ....” For example, the authors found that the number of freestanding (non-hospital) MRI units in the United States increased 133 percent from 1999 to 2001, and that “... more availability is associated with higher use and more spending.”<sup>63</sup>

There is a continuing debate over the effectiveness of CON laws in controlling health care costs. A number of studies find that they are not effective:

- The author of *American Health Care* concludes “... the costs of CON laws, although unquantified, are likely substantial while the benefits are empirically unproven.”<sup>64</sup> Studies cited by the author find that CON programs have failed to achieve cost containment and are likely to result in substantial direct and indirect costs. The analysis suggests that CON laws protect existing institutions from competition by discouraging new competitors, thereby limiting the choices available to consumers and increasing costs.<sup>65</sup>
- A 2004 report by the Federal Trade Commission and the Department of Justice found that “CON programs are not successful in containing health care costs and, indeed, pose serious anticompetitive risks that outweigh their purported economic benefit.”<sup>66</sup>
- A recent report by the Washington State Policy Center labels CON programs as a “Failure of Government Central Planning,” finding that they are costly and time consuming, suppress competition and do not restrain costs.<sup>67</sup>

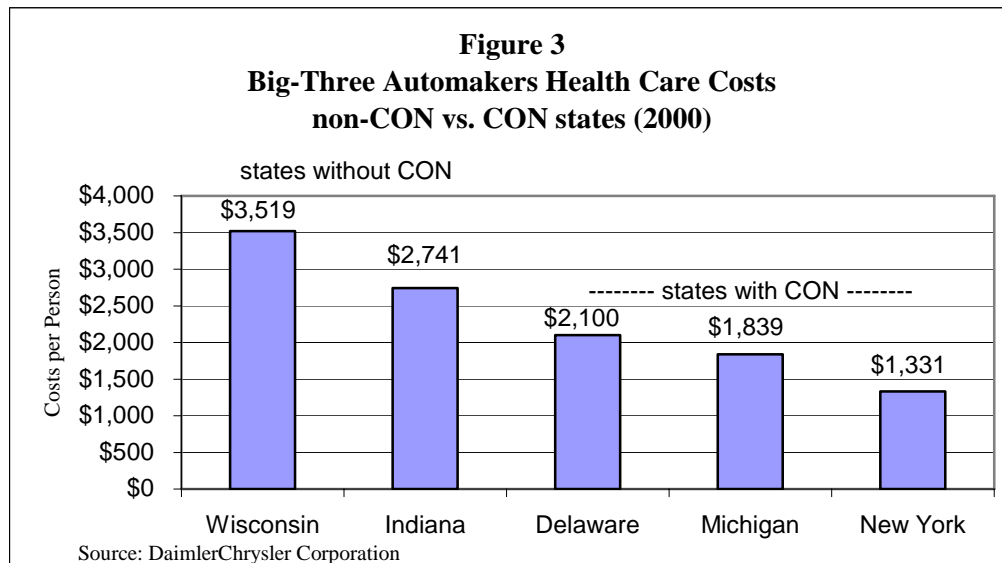
In contrast, some analysts assert that there are “glaring market imperfections” driving health care costs that CON regulation can address, including:

... the mediating influence of service selection and purchasing intermediaries such as insurance, Medicare, physicians and other health care professionals, the lack of price and quality information, legislatively-imposed service mandates,

cross-subsidization within the system, and service to all in urgent and emergency circumstances regardless of ability to pay.<sup>68</sup>

The American Health Planning Association argues that community-based health care planning and CON regulation are intended to compensate for these market imperfections and have had some positive impact on hospital capital expenditures.<sup>69</sup>

A review for the DaimlerChrysler Corporation, Ford Motor Company and General Motors of states with automobile plants found that CON states have lower health care costs than non-CON states. In Figure 3 below, Wisconsin and Indiana are states without CON laws and Delaware, Michigan and New York are states with CON laws.<sup>70</sup>



There may be a relationship between CON laws and quality of care. This is because CON regulations limit the number of hospitals offering specialized medical services, concentrating expertise. A 2002 study published in the *Journal of the American Medical Association (JAMA)* found an association between heart bypass surgery and CON regulation; patients in states with CON regulatory programs had a 22 percent lower risk of death.<sup>71</sup>

A 2005 RAND report concludes, “The empirical evidence regarding CON laws is mixed.” The authors reviewed a number of studies and found that there is no evidence that CON laws have significantly reduced overall medical spending, although they have slightly reduced capacity and long-term acute care spending. CON laws have increased costs per inpatient day and per admission, a not unexpected finding since one of their purposes is to reduce the number of hospital admissions. Finally, the review finds that CON laws have not affected access to care or the diffusion of hospital-based medical technologies.<sup>72</sup>

The RAND report was written to advise the State of Louisiana as it rebuilds its healthcare system after Hurricane Katrina. The authors note that reconstructing New Orleans’

health care system is one of the most important post-Katrina tasks, and that the “Policy levers available to the State include Certificate of Need regulation, licensure, control of conversions [non-profit to for-profit] and mergers, redesigning Medicaid reimbursement schedules, and financial incentives such as pay-for-performance.”<sup>73</sup>



## NOTES

- <sup>1</sup> Government Accountability Office, "Highlights of a GAO Forum," *Health Care: Unsustainable Trends Necessitate Comprehensive and Fundamental Reforms to Control Spending and Improve Value*, January 2004, p. 3.
- <sup>2</sup> See Roger D. Feldman, *American Health Care*, The Independent Institute, Oakland, California, 2000, and Patrick John McGinley, "Beyond Healthcare Reform: Reconsidering Certificate of Need Laws in a Managed Competition System," *Florida State University Law Review*, 1995.
- <sup>3</sup> Bruce Darwin, *A Review of Certificate of Need Health Care Policy Programs: At the Intersection of Science and Politics*, presentation to the Washington State CON Task Force, January 3, 2006.
- <sup>4</sup> See American Health Planning Association, *Improving Health Care: a Dose of Competition; AHPA Response*, accessed from the AHPA website.
- <sup>5</sup> Charles E. Phelps, *Health Economics*, HarperCollins Publishers Inc., 1992, p. 468.
- <sup>6</sup> U. S. Department of Health, Education and Welfare, *Health Care Facilities, Existing and Needed*, HEW Publication No. (HSM) 72-4004, Maryland, 1971, p. 12.
- <sup>7</sup> R. Llewelyn-Davies, H.M.C. Macaulay, *Hospital Planning and Administration*, World Health Organization, Geneva, 1966, p. 9.
- <sup>8</sup> 79<sup>th</sup> Congress, House of Representatives, *Hospital Survey and Construction Act; Report*, Committee on Interstate and Foreign Commerce, Report No. 2829, 1947, p. 4.
- <sup>9</sup> American Hospital Association, *Transcript of the Institute on Hospital Planning*, Chicago, 1947, pp. 7, 21-24.
- <sup>10</sup> R. Llewelyn-Davies, H.M.C. Macaulay, *Hospital Planning and Administration*, World Health Organization, Geneva, 1966, pp. 24, 32.
- <sup>11</sup> R. Llewelyn-Davies, H.M.C. Macaulay, *Hospital Planning and Administration*, World Health Organization, Geneva, 1966, p. 16.
- <sup>12</sup> R. Llewelyn-Davies, H.M.C. Macaulay, *Hospital Planning and Administration*, World Health Organization, Geneva, 1966, p. 19.
- <sup>13</sup> Charles E. Phelps, *Health Economics*, HarperCollins Publishers Inc., 1992, p. 464.
- <sup>14</sup> U. S. Department of Health, Education and Welfare, *Health Care Facilities, Existing and Needed*, HEW Publication No. (HSM) 72-4004, Maryland, 1971, p. 9.
- <sup>15</sup> Comptroller General of the United States, *Review of Certain Aspects of the Hill-Burton Health Facilities Construction and Modernization Program*, May 31, 1974, p. 2.
- <sup>16</sup> California Health and Safety Code, Chapter 3 at § 430 etc., repealed in 1995.
- <sup>17</sup> State of California, Department of Health, Office of Statewide Health Planning and Development, *Certificate of Need Program: Historical Background*, Sacramento, January 1978, pp. 1-2.
- <sup>18</sup> State of California, Governor's Committee on Medical Aid and Health, *Health Care for California*, Department of Public Health, December 1960, p. 40.



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- <sup>19</sup> State of California, Governor's Committee on Medical Aid and Health, *Health Care for California*, Department of Public Health, December 1960, pp. 41-44.
- <sup>20</sup> State of California, Governor's Committee on Medical Aid and Health, *Health Care for California*, Department of Public Health, December 1960, p. 7.
- <sup>21</sup> State of California, *Report of Regional Committees for Hospital Planning*, December 1964, p. 12.
- <sup>22</sup> James A. Hamilton Associates, *A Hospital Plan, the Sacramento Area*, Minneapolis, Minnesota, February 1962, pp. 1-5.
- <sup>23</sup> State of California, *Report of Regional Committees for Hospital Planning*, December 1964, p. 2.
- <sup>24</sup> See Hilary G. Fry, *The Operation of State Hospital Planning and Licensing Programs*, Hospital Monograph Series No. 15, American Hospital Association, Chicago, Illinois, 1965, p. 71.
- <sup>25</sup> State of California, The Hospitals and Related Health Facilities And Services Planning Committee, "Cover Letter from Lawrence T. Cooper, Chairman," *Voluntary Regional Planning: Hospitals and Related Health Facilities and Services*, Sacramento, December 1969.
- <sup>26</sup> State of California, The Hospitals and Related Health Facilities And Services Planning Committee, *Voluntary Regional Planning: Hospitals and Related Health Facilities and Services*, Sacramento, December 1969, p. 14.
- <sup>27</sup> See Hilary G. Fry, *The Operation of State Hospital Planning and Licensing Programs*, Hospital Monograph Series No. 15, American Hospital Association, Chicago, Illinois, 1965, p. 68, for a list of groups pressuring state healthcare planning agencies.
- <sup>28</sup> State of California, The Hospitals and Related Health Facilities And Services Planning Committee, *Voluntary Regional Planning: Hospitals and Related Health Facilities and Services*, Sacramento, December 1969, p. 35.
- <sup>29</sup> State of California, The Hospitals and Related Health Facilities And Services Planning Committee, *Voluntary Regional Planning: Hospitals and Related Health Facilities and Services*, Sacramento, December 1969, pp. 5, 32.
- <sup>30</sup> Douglas R. Brown, "Abstract," *The Areawide Hospital Planning Process*, Doctoral Dissertation, Cornell University, New York, March 1971.
- <sup>31</sup> State of California, The Hospitals and Related Health Facilities And Services Planning Committee, *Voluntary Regional Planning: Hospitals and Related Health Facilities and Services*, Sacramento, December 1969, p.7.
- <sup>32</sup> Government Accountability Office, "Highlights of a GAO Forum," *Health Care: Unsustainable Trends Necessitate Comprehensive and Fundamental Reforms to Control Spending and Improve Value*, January 2004, p. 3.
- <sup>33</sup> United States General Accounting Office, *Health Care Facilities: Capital Construction Expenditures by State*, B-223870, August 11, 1986, p. 3.

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- <sup>34</sup> State of California, Department of Health, Office of Statewide Health Planning and Development, *Certificate of Need Program: Historical Background*, Sacramento, January 1978, p. 15.
- <sup>35</sup> See for example, Comptroller General of the United States, *Planning, Construction, And Use of Medical Facilities in The San Francisco Bay Area*, October 13, 1971, p. 1.
- <sup>36</sup> Comptroller General of the United States, *Review of Certain Aspects of the Hill-Burton Health Facilities Construction and Modernization Program*, May 31, 1974, p. 3.
- <sup>37</sup> State of California, Department of Health, Office of Statewide Health Planning and Development, *Certificate of Need Program: Historical Background*, Sacramento, January 1978, p. 15.
- <sup>38</sup> Comptroller General of the United States, *Review of Certain Aspects of the Hill-Burton Health Facilities Construction and Modernization Program*, May 31, 1974, pp. 21-22.
- <sup>39</sup> Comptroller General of the United States, *Comprehensive Health Planning as Carried Out by State and Areawide Agencies in Three States*, April 13, 1974, p. 11.
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- <sup>41</sup> Assembly Committee on Health, "Testimony by Mr. Wagstaff," *Interim Hearing on The High Cost of Medical Care*, Vol. 1, State Capitol, Sacramento, October 15, 1975, p. 16.
- <sup>42</sup> Assembly Committee on Health, "Testimony by Saleem Farag," *Interim Hearing on The High Cost of Medical Care*, Vol. 1, State Capitol, Sacramento, October 15, 1975, p. 94.
- <sup>43</sup> Office of Statewide Health Planning and Development, California Department of Health, *California Certificate of Need Review Process*, Sacramento, California, May 1977, p. 3.
- <sup>44</sup> Office of Statewide Health Planning and Development, California Department of Health, *California Certificate of Need Review Process*, Sacramento, California, May 1977, p. 3.
- <sup>45</sup> Office of Statewide Health Planning and Development, California Department of Health, *California Certificate of Need Review Process*, Sacramento, California, May 1977, p. 2.
- <sup>46</sup> State of California, Office of Statewide Health Planning and Development, *The Problem of Rising Health Care Costs; California's thrust on containment through the Certificate of Need Program*, the Department of Health, January 1978, p. 16.
- <sup>47</sup> Interview with John Roskopf, July 7, 2006.
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- <sup>49</sup> Barbara W. Greenman, *State-Local Health Planning Linkages*, Institute of Health Planning Monographs, U.S. Department of Health & Human Services, November 1984, p. 2.
- <sup>50</sup> United States General Accounting Office, *Health Care Facilities: Capital Construction Expenditures by State*, B-223870, August 11, 1986, p. 4.
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- <sup>52</sup> Charles E. Phelps, *Health Economics*, HarperCollins Publishers Inc., 1992, pp. 349-350.

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- <sup>53</sup> Charles E. Phelps, *Health Economics*, HarperCollins Publishers Inc., 1992, p. 266.
- <sup>54</sup> United States General Accounting Office, *Health Care Facilities: Capital Construction Expenditures by State*, B-223870, August 11, 1986, p. 6.
- <sup>55</sup> Barbara W. Greenman, *State-Local Health Planning Linkages*, Institute of Health Planning Monographs, U.S. Department of Health & Human Services, November 1984, pp. v-ix.
- <sup>56</sup> Roger D. Feldman, *American Health Care*, The Independent Institute, Oakland, California, 2000, p. 179.
- <sup>57</sup> Roger D. Feldman, *American Health Care*, The Independent Institute, Oakland, California, 2000, p. 172.
- <sup>58</sup> See Charles E. Phelps, *Health Economics*, HarperCollins Publishers Inc., 1992, pp. 465-466 for a description of the complex formula and calculations used in New York to determine the need for additional healthcare facilities.
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- <sup>65</sup> Roger D. Feldman, *American Health Care*, The Independent Institute, Oakland, California, 2000, pp. 178-183.
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<sup>72</sup> Andrew Dick, Soeren Mattke, "The Level of State Involvement in the Reconstruction of the Municipal Healthcare System," *Working Paper*, RAND, WR 308, October 2005, p. 6.

<sup>73</sup> Andrew Dick, Soeren Mattke, "The Level of State Involvement in the Reconstruction of the Municipal Healthcare System," *Working Paper*, RAND, WR 308, October 2005, p. 1.